A Study of Depression in Second Generation South Asian Women in Scotland

Eddie Donaghy

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I declare that the contents produced in this thesis to be the individual work of Edward Donaghy.

Signed....

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THE UNIVERSITY OF EDINBURGH

ABSTRACT OF THESIS

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Name of Candidate EDWARD DONAGHY

Address 9/1 SIENNA GARDENS, EDINBURGH, EH9 1PQ

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In Britain the earliest studies on mental illness in the South Asian community took place in the 1960s and suggested that South Asians had higher levels of mental ill-health. Until quite recently, however, it has been suggested, partly on the basis of some of these studies being methodologically flawed, that the South Asian community actually had lower rates of mental illness than indigenous white communities. This claim was based on a number of factors, one of the most prominent being the that the South Asian extended family was all supportive and buffered it's members from the stresses of everyday living.

The role of stressful experiences, often termed severe life events, in the onset and recurrence of a range of mental disorders has been established in a plethora of studies as has the benefits of social support in buffering or preventing such stresses. In one of the most widely cited studies on depression, Brown and Harris (1978), found that severe life events in the absence of social support (most notably a confiding relationship) increased the risk of depression in working class women in Camberwell, London.This and subsequent studies have emphasised that severe events associated with loss of a cherished idea or aspiration, often associated with a social role, featured as the main severe life events. Also implicated in the onset of depression were on-going major difficulties and, to a lesser extent, severe events not involving loss.

This thesis investigated the nature of severe life events and strength of social support in two groups of second generation South Asian women in Scotland, one with and one without depression, using a semi-structured interview approach. The development of mental illness caused by the stresses of migration have been found in minority populations in studies throughout the world. The process of acculturation, the adaptation of cultural traditions by ethnic minority groups to facilitate living in and with majority white indigenous communities, can be a stressful experience on a number of fronts.This can be particularly so for women from ethnic communities, such as those found in the South Asian community, which lay emphasis on the role of women in the maintenance of cultural traditions. For some women, conflicts can arise out of this process and develop into severe life events. In the absence of social support such conflicts, according to the Brown and Harris model of depression, increase the risk of these women developing depression.

This thesis addresses the methodological issues of cross-gender and cross-'race' research. It gives an overview of the diverse experiences of second generation South Asian women in Britain and abroad. It contends that as a consequence of the acculturation process, conflicts over gender can arise. It concludes by asserting that second generation South Asian women can experience loss of a valued idea or aspiration associated with a social role and that such an experience constitutes a severe life event, which in the absence of a strong confiding relationship, increases the risk of depression in these women. To a lesser extent this is also the outcome where on-going major difficulties and severe event without loss is experienced. The Brown and Harris model of depression is, therefore, relevant when considering the mental health of second generation South Asian women in Britain and abroad.

CONTENTS

Introduction

The 1991 Population Census showed that Scotland, albeit to a lesser degree than the rest of the UK, is a multi-cultural society made up of a diverse range of ethnic communities, including people of Irish, Italian, Ukrainian, and African background. The largest ethnic minority grouping identified in the census were people of South Asian origin* (For a breakdown of Scotland's South Asian population, see Appendix 1b). Multi-culturalism is a widely defined, often contentious issue. Robert Hughes (1993), acknowledging the awkwardness of the term, provides in my opinion a useful definition when he states :

"Multiculturalism asserts that people with different roots can co-exist, they can learn to read the image banks of others, that they can and should look across the frontiers of race, language, gender and age without prejudice or illusion, and learn to think against the background of a hybridised society. It proposes - modestly enough - that some of the most interesting things in history and culture happen at the interface between cultures. It wants to study border situations, not only because they are fascinating in themselves, but because understanding them may bring with it a little hope for the world. Separatism denies that value, even the possibility, of such a dialogue. It rejects exchange." (Hughes, 1993: 84-85).

In 1987 whilst working in Bradford (a town in Yorkshire with a large South Asian population), my work on low pay and unemployment introduced me to large numbers of women of South Asian origin most of whom were born in the Yorkshire area. In a number of discussions/meetings it was clear that large numbers of South Asian women from Bradford's housing schemes identified to varying degrees with cultural/religious values whose origins lay in the Indian subcontinent. At the same time large numbers of these women, particularly the youth and/or those born in the UK, simultaneously identified with values and opinions

* This term shall be used throughout this thesis to refer to the interviewees who participated in this study and those who have been the focus of other similar studies referred to in this work. In using the term South Asian, I refer to those people whose parents were born in the Indian subcontinent, i.e., India, Pakistan and Bangladesh. The term does not suggest a homogenous grouping of people and acknowledges the variations in language, culture, religion, class and caste that exist.

held by young white indigenous women in Yorkshire and throughout the UK. Subsequently there existed a diversity of experience, outlook

and opinions; women who placed strong emphasis on the importance of religion, marriage and the family; women who emphasised the importance of careers and independence, women who believed in the centrality of religion and the family but also the importance of careers and a certain degree of independence; women who believed in the former following their experiences of the later and vice-versa. In some instances such experiences resulted in a widening of the borders between divergent value systems found in the South Asian community and the white majority cultures; in other instances there was a blurring of the borders. This was the result, in effect, of experiencing the interface between diverging cultures and border situations that Hughes (1993) refers to.

It is against this backdrop that I was drawn to the work of Brown and Harris following their study on depression in working class women in Camberwell London (*The Social Origins of Depression. Brown and Harris, 1978*). Many other studies into mental illness have taken and do take a 'checklist' approach to identifying factors that can result in individuals being at greater risk of developing mental health problems. A typical list includes: divorce, pregnancy, moving house, being made reduntant, moving jobs etc. Whilst acknowledging that these experiences were significant and potentially stressful life events and had the potential to increase the risk of a person developing a mental health problem, Brown and Harris argued that the risk was significantly influenced by the individual's personal situation. They referred to this as the person's biographical details. For example, a professional woman married/living with a professional man who had planned to have children, was without financial insecurities and who had strong support available from family and friends would view the news of pregnancy very differently to that of a single mother, unemployed, financially insecure and who found out she was pregnant with a child she neither planned or desired. Whilst both would cross off the box marked pregnancy on a checklist, receiving the same score, the differing perspectives on the impending pregnancies would be unknown

without discussing with the women their personal views on the matter. Brown and Harris's fundamental point in their approach was that to understand the impact of life event/s such as pregnancy in women one would have to take account of the woman's views on the matter. The nature and impact of a particular event depended on that person's view on the matter taking into

account their social circumstances and aspirations. In addition to this point, Brown and Harris noted that the experience of a life event did not in and of itself result in the onset of depression. The availability of social support, in particular a person to confide in and discuss one's problems, also had a significant impact on whether or not a person became depressed. In summary, they suggested that stressful life events coupled with a vulnerability factor (notably poor social support through having no one to confide in) could increase the risk of a woman becoming depressed. The applicability of what has become known as the Brown and Harris model has been widely replicated in a number of research projects among diverse British communities in London, Edinburgh and the Outer Hebrides as highlighted by Champion (1990) and in overseas countries as diverse Kenya and Denmark (Fava et al 1981; Vadher & Ndetei, 1981).

In deepening their analysis of the 1978 research in Camberwell, Brown and Harris went further by emphasising the importance, if the risk of depression is to be reduced, of achieving/attempting to achieve a sense of value in oneself relating to a particular social role/s and the positive feelings an individual attained from fulfilling/attempting to fulfil such a role/s. With this phenomenon in mind, at a later stage, Brown and Prudo (1981), carried out research in the Outer Hebrides. In discussing their findings, they identified the limited roles available to Hebridean women, centring mainly on the role of mother, daughter, wife, and sister. The importance of loyalty to one's family was also of central importance to the women and that following the death of a close relative, the risk of depression was greatly increased in traditional Hebridean women. Brown and Prudo argued that the death of a close relative brought into question and endangered the role/s of these women, thus increasing the risk of them becoming depressed. Furthermore, they also noted that some women who moved away

from the traditional crofting roles of women and moved into a more urban existence living in council estates also had a increased risk of depression. In a revealing insight, Brown and Prudo noted that the circumstances differed slightly from those of the London women in Camberwell where a more 'metropolitan' environment was more tolerant of re-marriage and provided a population centre so large that alternative relationships and greater access to a range of roles were more available. However, subsequent studies by Brown among working class women in London (e.g., his 1986 study in Islington) also revealed the importance to these women, in a different context from that of Hebridean women, of social roles and how conflict arising from divergent obligations, particularly between domestic and external sphere, was related to an increased risk of depression. Brown and Harris, and those adopting their model, believe that a number of life events, especially those relating to loss and chronic strains could, in the absence of social support, increase the risk of women becoming depressed. These events can be summarised as follows;

Severe Events Involving Loss.

Such events broke down into 3 main categories

(i)Severe events involving loss associated with a particular role. This involved experiencing an event/s resulting in the loss of a valued goal/aspiration which centred on a specific social role. This could include a woman's business collapsing and being unable to work in a particular field they desired. It could be a mother on hearing news that her teenage daughter had become pregnant and felt that she was a poor mother and parent because of her daughter's predicament It also included the prevention of achieving a valued goal/aspiration relating to a particular social role. This could involve being prevented by family from going to university and becoming a doctor or pharmacist, or going to college to study art. This is consistent with the idea that it is not merely loss itself that is critical in depression, it is also about being prevented from the possibility of achieving a role, or adopting certain values and attitudes to which the woman aspired.

(ii) Loss through a specific event. For example loss through death, loss through divorce, loss through miscarriage negatively affecting the fulfilment of a particular role associated with wife or mother.

(iii) Severe Event Without Loss. For example, witnessing a murder or serious car accident.

Chronic Strains and Stresses

These involved strains and stresses that lasted for at least two years and included on-going poverty, housing problems, long-term unemployment the experience of marital disputes.

Following my experience of working in Bradford, by drawing on a small research project I carried out on mental illness among women in two Edinburgh housing schemes, and influenced by the Brown and Harris approach to the social origins of depression, I undertook an investigation of life events and stressful experiences and the level of social support, specifically the strength of confiding relationships in 46 South Asian women living in Glasgow and Edinburgh. The aim was to establish, through discussion, what the women regarded as important life events, why they were important and how these events impacted on their lives. At the same time, the study aimed to assess the strength and nature of confiding relationships and their importance in buffering life events, and their impact in potentially reducing the risk of depression.

Why did I draw on the work of Brown and Harris in attempting to gain an insight into life events, social support and depression in second generation South Asian women in Scotland? Firstly, as discussed briefly above but in greater detail in Chapters 3 and, the Brown and Harris method of investigating and understanding life events and their relationship to depression emphasised the importance of the South Asian women themselves discussing and describing their own personal experiences, attitudes and outlook and how

these came together to impact on their mental health. Secondly, whilst recognising that direct comparisons could be suspect because of certain gendered experiences and ethnic differences, I believed that the basic approach of Brown and Harris' original work could be adopted in research on depression among South Asian women in this country.

Within South Asian families there are ideas with regard to traditional roles of women and family loyalty that are not dissimilar to those found in the Hebridean families studied by Brown and Prudo. The concept of *izzat* (male and family honour) is one of central importance in many South Asian families. Anything that challenges *izzat* and/or *biradari* (the wider family network) is often conceived by the heads of the family as bringing dishonour on to the family. The demand for women to conform to individual roles and family expectations is often strong and deviation from this, in whatever form, can often lead to conflicts and distress. This can result in difficulties among two main groups of women: (i)those who carry out their expected roles but are dissatisfied with them and (ii)those who deviate from expected roles and become engaged in conflict with the immediate family and community. It is worth noting at this point the work of Merrill (1988; 1989; 1990) and Mumford (1991b), who reported that role conflict correlated highly with feelings of hopelessness and suicidal intent among young South Asian women and that conflicts over traditional behaviour and dress for South Asian girls led to eating disorders. Equally important in this context is the work of Beliappa (1991), who found that South Asian women dissatisfied and in conflict over their perceived roles constituted a group at high risk of developing depression. Beliappa noted that it was the social role of women that resulted in the conflict and that since female roles were linked fundamentally to the family, women were more vulnerable to psychological distress arising out of role conflicts between them and their family.

As one of a number of factors that can shape a person's personality and outlook, family experiences are important when considering the importance of a person's identity and their ideal social role and how these impact on mental health. In her study of mental illness in a South Asian community in London, Beliappa (1991) found judgement of self to be based on

relationships with significant others, in this case the individual's family. Low self-esteem resulted from an inability to fulfil expected roles or loss of meaning associated with the roles. Following their initial 1978 Camberwell survey, Brown and Harris emphasised the importance, if the risk of depression in women is to be reduced, of locating alternative sources of value. For Brown and Harris, the location of such values takes place in the social and cultural contexts the women find themselves. In such contexts the emphasis on particular social roles and expectations surrounding such roles influence the possibility of fulfilling such aspirations surrounding a valued role. As with white indigenous women, some South Asian women can experience restrictions from within their immediate family in their attempts at striving to fulfil valued goals relating to a particular role, as Ahmed (1981), Merrill (1986;1990), Beliappa (1991) and Patel (1991) have noted. One could postulate that South Asian women who experience restrictions in achieving desired roles, and/or experience conflict as a result of acting out present roles, may find themselves in a situation where it is difficult for them to see how they can achieve alternative valued roles linked to their own personal aspirations . Such a situation could deprive them of a vital source of self-esteem. Given that their ability to confide in their immediate family is reduced, as this is often where the source of such conflict occurs, such women could be deprived of much needed support. Given the role of life events and poor social support in increasing the risks of a person developing depression, such a situation could lead to South Asian women becoming depressed.

In addition to the desire to achieve valued goals/aspirations, a number of studies (e.g. Brown, 1984) have shown that ethnic minority communities in Britain, including South Asians, can be at greater risk of experiencing chronic strains of long-term unemployment, low pay, poor housing and daily experiences of racial harassment.

As Chapter 1 highlights, many recent studies involving young South Asian women and mental illness have cited "*culture conflict* " as the major reason for their onset of mental health problems. This assertion is in my opinion problematic. Most cultures are not confined

parcels, all homogenous, one thing or the other and impenetrable to influence and change. As a Scot of Irish grandparents, brought up as a Roman Catholic in a Edinburgh housing scheme, my own cultural, social influences are varied and in many ways distinct from people in other areas of Edinburgh. If this varied experience can exist in Edinburgh, how much more so than in the rest of Scotland. People can and do draw on a range of experiences in developing their own identity and outlook and, I believe, this is the case with ethnic minorities. Even those with great pride in their own cultural and religious practices can draw on other values and practices. In an interview in 1984 for the *Third World Book Review* CLR James, the well known and outspoken Black nationalist, made a telling statement when, discussing his own cultural heritage, values and identity. He said :

"How am I to return to non-European roots? If it means that Caribbean writers today should be aware that there are emphases in their writing that we owe to non-European, non-Shakespearean roots, and the past in music that is not Beethoven, that I agree. But I don't like them posed there in the way they have been posed either-or. *I don't think so. I think* both *of them*".

The processes that come into play at the borders between distinct ethnic minority and majority cultural groups can result in the exchange, to varying degress, of particular values and practices on both sides. For some ethnic minority group members the process of exchange has the potential to result in conflict with their immediate family community members who may feel that their cultural and religious values and practices may be in danger of being diluted or swamped by majority cultures and practices.

The origins of this thesis is based on my experience of working in Bradford. Some of the women I had worked with developed mental health problems, notably depression, following very stressful acute events often tied up with their experience of border situations. Some women who had similar acute experiences did not develop depression. At the same time, some women who had no desire to experience and/or did not experience border situations,

whose values and outlooks were closely identified with their immediate family and country of origin, also experienced mental health problems whilst women of a similar attitudes had no mental health problems. Diversity of experiences was the main lesson learnt from these meetings and it is the diversity of experiences regarding identity, outlook, values, personal aspirations, the nature and impact of life events, their levels of social support and the impact of all of these on the mental health of the 46 Second generation South Asian women from Glasgow and Edinburgh that is investigated in this thesis.

Plan of the Dissertation

The thesis begins with a literature review in Chapter 1 which covers all the main findings from studies into the mental health of South Asians in Britain. It starts with some of the earliest studies in the 1960s, highlighting some of the deficiencies in such studies, before moving on to consider the presentation and understanding of mental ill-health in culturally diverse populations. The chapter then discusses mental illness in second generation South Asian women, particularly depression, recognising the growing number of attempted suicides and certain disorders such as bulimia and anorexia nervosa, previously only thought to exist in 'typically' western populations.

Given that the focus of the thesis is on the nature and content of life events and their role in onset of depression, the second half of Chapter 1 takes an in-depth look at the concept of self-esteem, particularly in ethnic minority populations, where a debate has taken place over a number of years on whether black and ethnic minorities have lower self-esteem (and therefore are more at risk of developing depression) because of racial discrimination. It concludes by stating that this approach is somewhat simplistic and, that on the basis of an extensive review of numerous studies in this area, evidence for such a conclusion is weak. Instead, one has to look in more depth at the everyday experiences of ethnic minority communities: in the case of this thesis, at the everyday experiences of second generation South Asian women in Scotland. As I address Section II of the first chapter, there are certain similarities in British South Asian communities which are present (see footnote) and there are certain groupings

and individuals (particularly, although not exclusively with migrant communities), who wish to see no change in certain customs/practices originating from their country of birth , some of which have in fact diminished over time in these respective countries . In parenthesis, my doubts regarding the use of the all encompassing "culture conflict" as a means of understanding life events among South Asian women lies in it's application in precluding , or potentially precluding, a more responsive approach and an enhanced understanding as to why a young South Asian person develops depression. In attempting to understand research findings about why South Asian young people experience mental health problems such as depression, researchers need to be more prepared to appreciate their complexity and avoid reductionism arising from single-factor explanations.

It is my intention in this thesis to demonstrate that because of their everyday experiences in this country, second generation South Asian women are not immune from similar social, cultural and peer pressures to those experienced by white indigenous women and girls. Consequently, a number of South Asian women will develop values and aspirations and exhibit behaviours similar to their white indigenous counterparts. Chapter 2 looks into the socialisation experiences of second generation South Asian women in western countries. It does this in the context of the theories relating to ethnic minority adaptation processes, in particular the theory of acculturation, and highlights the fact that some of these adaptation processes can lead to tensions within South Asian minority communities, particularly over the traditional roles and behaviour of women. It goes on to examine the role of women in South Asian families both in their countries of origin and their countries of migration. The chapter then considers how some of the tensions that emerge out of the adaptation processes, especially in women, can become stressful life events and can potentially be factors in the onset of depression among this section of the community. Based on my personal experiences in Bradford, in Scotland, and on the basis of the research involved for this thesis I believe we should recognise the existence of disparate beliefs, practices and everyday experiences of young South Asian women which is in contrast with the picture that is often painted of South Asians in the UK , i.e., a homogeneous group bound together by common religious and

cultural practices. Chapter 2 highlights the diversity of adaptation and change that occurs in second generation South Asian women by examining studies on this phenomenon in a general global way and specifically among the women who participated in this study in Scotland. In doing so, it describes the views of women in Scotland who took part in this study on the acculturation process, specifically identity, marriage and women's roles. Based on existing literature, my own personal experiences and discussions with South Asian women in Scotland and in Bradford, I see acculturation as a multi-dimensional process arising out of the interaction between ethnic minorities and indigenous majority groups. The absorption of values and practices of majority cultures and their implementation in the everyday lives of ethnic minority groups is diverse. I would categorise these processes as ranging from non-embracing, partial embracing, mainly embracing and all embracing. Furthermore, the process of adaptation and change as a consequence of the acculturation process is not static, not written in tablets of stone and not irreversible. The process of adaptation and change however can result in conflict for some women.

The method of ethnography has been and remains an area of contention in social science research. Where this method is used in a cross-gender, cross-cultural and cross-'race' setting, a number of important methodological questions are raised. As my study contained all three of the aforementioned settings, Chapter 3 addresses the contentious methodological issues, both theoretically and empirically, arising from research similar to my own. It concludes by stating that in studies of this nature there often lies a questionable presupposition - that the validity of interviewees' replies and comments is heavily dependent on whether or not the interviews are carried out by same-sex and/or same-'race' interviewers. This conclusion is, in my view, reductionist and researchers, whilst acknowledging the part they can potentially play in the findings of such research, should be more prepared to recognise the complexity of research findings in studies of this nature. Chapter 3 also addresses the theoretical complexities surrounding the measurement of life events and social support before recounting the practicalities of how these factors were assessed in this study. In doing so, the question of the validity and reliability of using terminology and instruments

developed in western settings among non-western populations is also discussed. There is also an explanation as to how judgements of role conflicts were reached.

The analysis of my interview data is presented in Chapter 4 and Chapter 5. It is in these two chapters that the main findings of my research are set out, analysed, and discussed. This process is carried out against the backdrop of the main theoretical writings relating to life events, social support and the part both play in depression. Chapter 4 consists of two sections. Section 1 looks at the theoretical approaches to stress, social roles and life events and why it is believed all three are linked together as aetiological factors in the development of depression in women. The second half of Chapter 4 discusses the key research findings of my own study, and what this tells us about social roles, life events and their influence in the onset of depression in second generation South Asian women who participated in the study. As previously stated, social support is recognised as being of particular importance in depression. Chapter 5 takes a critical look at the numerous approaches to the definition of and measurement of social support. It argues that the most effective way of measuring this phenomenon is by an assessment of confiding relationships in line with the Brown and Harris model of depression. The chapter discusses the most reliable way of assessing the strength of confiding relationships in my sample then goes on to comment on the importance of this form of social support in the onset or reducing the risk of depression in second generation South Asian women.

As this study hopefully demonstrates, mental illness in Scotland's South Asian community is not solely dependent on experiencing acculturative stresses. It is not always those who sought change and a moved towards values and practices associated with the majority cultures who become depressed. Likewise, not everyone who encompassed change and adopted such values and approaches become mentally ill.

The concluding argument on the acculturation process and mental health is that whilst the acculturation process has the potential to be a powerful predictor in increasing the risk of mental

illness, it is not a global interpretation of risk in ethnic minorities. Not everyone who experiences stresses and strains as a result of the acculturation process will develop a mental illness. There are no fixed patterns of outcome, no universal direct causal links. Other factors, including immediate family attitudes to change and, especially, social support in the form of strong confiding relationship/s, can influence whether or not a person becomes depressed. Complexity of experiences and variation in the outcome of such experiences among Second Generation South Asian women was a central feature in this study, that includes the pro-change and no-change individuals. The importance of events both daily and long-term, of an individual woman's value systems, aspirations and their outcomes, as described by a woman themselves, along-side their levels of social support are in my opinion central features in understanding depression in Scotland's South Asian community.

Further evidence regarding the diversity of stressful events resulting in depression comes from the experiences of women in the study who became depressed following specific events that played a key role in them becoming depressed. A number of women became depressed after experiencing loss through death of a loved one and loss through divorce and separation from a partner. Additionally there was a woman who experienced a severe event where loss was not the central factor. This women became depressed after being sexually harassed in Pakistan. There were women who experienced major strains and difficulties lasting for a number of years such as inter-family disputes over business ventures and housing arrangements. In addition, there are other factors such as the chronic strains of poverty and racism which increased the risk It was significant that these women experienced these events in the absence of supportive confiding relationships.

Diversity of experience regarding the nature and outcome of the acculturative process, diversity of experience regarding loss and diversity of experiencing regarding chronic strains were evident and existed in this study of second generation South Asian women. The onset of depression was influenced by a range of factors and the level of confiding social support was an substantial component in influencing whether or not women became depressed following such

diverse experiences. My concluding view is that, whilst recognising the diversity of experiences within Scotland's South Asian community, the basic approach outlined by Brown and Harris (1978) has a relevance in studies of depression among Second Generation South Asian women in Scotland.

Coding

When referring to the interviewees I shall do so by where they are from, their religion and a number, d= depressed, nd= non-depressed. For example gm1d is Glasgow Muslim Depressed Interviewee number 1. The abbreviations are;

gmd = Glasgow Muslim Depressed

gsd = Glasgow Sikh Depressed

ghd = Glasgow Hindu Depressed

ehd=Edinburgh Hindu Depressed

emd=Edinburgh Muslim Depressed

esd= Edinburgh Sikh Depressed

gmnd = Glasgow Muslim Non-depressed

gsnd = Glasgow Sikh Non-depressed

ghnd = Glasgow Hindu Non-depressed

ehnd=Edinburgh Hindu Non-depressed

emnd=Edinburgh Muslim Non-depressed

esnd= Edinburgh Sikh Non-depressed

Chapter1

Section 1:The Mental Health of South Asians in Britain.

Section 2: Self-esteem as a Concept and Self-esteem in Ethnic Minorities; A review of the Literature.

Section 1

The Mental Health of British South Asians

This chapter will review the research findings of mental health studies on South Asians living in Britain. Special emphasis will be given to the literature on mental illness in South Asian women living in Britain. This is followed by a review of literature on self-esteem and self-concept with particular reference to studies on ethnic minority self-esteem and self-concept. The purpose of this chapter is to highlight mental health in the South Asian community in Britain, particularly with respect to South Asian women. The chapter begins by examining early findings of mental health research in the South Asian community and why, as a result of certain deficiencies, some of the early findings are questionable. The following section then looks into the reasons put forward to explain alleged lower recorded rates of mental illness in this community and suggests that there may be differences between the first and second generation with respect to meaning, illness behaviour and presentation of mental illness. I argue that although there may be small differences in understanding of the concepts of mental health and mental illness between white and second generation South Asians, recent studies suggest there is more shared meaning of such concepts than differences. The chapter moves on to reveal research findings on depression, self-poisoning and eating disorders that have been found in second generation South Asian women over the past decade and, by drawing on recent research, explains why this should be the case.

The latter part of this chapter examines the notions of self-esteem and the self-concept. These two factors are implicated in depression and there is a wide literature on ethnic minority self-esteem and self-concept. Much literature alleges that, because of racism, ethnic minorities often have low self-esteem which affects their self-concept and are, therefore, more at risk of developing depression. I examine and review the studies on ethnic minority self-esteem that have been carried out in the USA and Britain. I conclude that the assertion of low self-esteem in blacks because of racism, although a theoretical and empirical possibility, is often used in a simplistic and reductive manner in an attempt to describe complex processes and behaviours and is, therefore, in my view open to question.

The Mental Health of South Asians in Britain : Early Findings

After an initial lack of interest in the years following the large scale migration to Britain in the 1950's and 1960's, the mental health of Britain's South Asian community began to generate some research. Several small studies in the 1960s appeared to highlight high morbidity rates among South Asian born subjects (Hashimi 1968; Bagley 1972). Most of these early studies, however, have been criticised on the grounds of small sample size and insufficient attention to variables such as age, sex, and social class (Rack,1982). In the late 1970s and early 1980s some larger scale surveys of hospital-admission figures took place. Cochrane (1977) obtained admission figures for all mental hospitals in England and Wales for 1971 and compared these with the 1971 census data on place of birth. Cochrane found low admission rates for both Indian-born (85 per cent of UK rates for males and 79 per cent for females) and Pakistani born (68 per cent of UK rates for both males and females). As Ineichen (1987) points out, place of birth does not equate with ethnic affiliation, and this study has been criticised for allocating those whose place of birth was not recorded (30 per cent of the sample) as UK-born. Leff (1982) disputed Cochrane's 1977 claims of lower rates of mental illness within the South Asian community. Leff re-analysed Cochrane's study and maintained that when the total rate is broken down into individual diagnoses, South Asians had higher rates of admissions for schizophrenia than the indigenous population, particularly amongst the Pakistani community.

A study of first time admissions to psychiatric hospitals in South-East England found high rates for Indians and low rates for Pakistanis (Dean et al..,1981). A study of first time admissions in Manchester between 1973 and 1975 (Carpenter and Brockington,1980) recorded significantly high rates for the South Asian group as a whole. Hitch (1981), in a study of first time admissions in Bradford between 1968-1970, found low rates for Indians and high rates for Pakistanis. Again, however, these studies have attracted criticism. Carpenter and Brockington (1980) did not distinguish between nationalities for all those born in the Indian sub-continent. These three surveys were limited to first-time admissions only, and are therefore not comparable with Cochrane's findings since in most British psychiatric hospitals re-admissions account for 30-60 per cent of all admissions (Rack,1982; 1985).

The above studies appear to throw up irreconcilable contradictions. In trying to reason with these findings, Ineichen (1987) states that differences in the characteristics of local communities and limitations of the research methodology probably contributed to the disparities among the findings from such studies. From these surveys it therefore seems reasonable to suggest that no consistent trends with respect to rates of mental disorders in the South Asian community in Britain can be detected. Furthermore, existing differences between this community and the white indigenous community, cannot be explained by simple generalisations. More recent studies appear to throw more light on mental illness in Britain's South Asian community.

More Recent Studies

Stern et al (1990) state that there is a general impression among those who work in areas with a large South Asian population that Asian children are under-represented in child psychiatry clinics. On the basis of their own study in London, Stern et al.. found that South Asian referrals were under-represented with respect to the local population but, contrary to their expectations, there were no significant differences between South Asian and non-South Asian groups with regard to demographic data, the nature of the presenting problem, and attrition rates.

A more recent study carried out by Thomas et al. (1993) examined the records of all acute psychiatric admissions of Europeans, Afro-Caribbeans and South Asians among residents in the central district of Manchester over a four year period. Rates of admission and re-admission for South Asians were similar to Europeans, except for the 16-29 age group, who tended to have lower rates. Thomas et al. (1993) state that caution should be exercised when interpreting these findings as the number of subjects within age stratified ethnic groups was small and there were difficulties in their study in estimating the various population denominators.

Cochrane and Bal (1989) compared admissions to mental hospital in England in 1981 with comparable figures for 1971. This study attempted to give a clearer overall picture of the mental health of immigrants to Britain by analysing national (England and Wales) psychiatric hospital data on both first and re-admissions to mental hospitals. The study found that 1981 admission rates for

immigrants from India and Pakistan (like 1971) were lower than native born rates. One noticeable feature of the study was the finding that Pakistani women had very low rates of admission for all diagnoses, as well as low re-admission rates. Because of national recording procedures, all the results reported in this study were based on country of birth and not ethnicity, thus excluding those born in England and Wales but belonging to the South Asian community. Thus the data in Cochrane's study only provided information on the foreign born, not the second generation born in England and Wales.

Although this study provided some interesting details, such studies do have their limitations. The hospital admission data reported is based on returns made to the DHSS on forms that must be completed for all admissions to and discharges from mental hospitals. As Cochrane and Bal (1989) point out, many of the forms returned to the DHSS are liable to variations in quality. Many are incomplete in some way and this appears to be a particular problem with recording place of birth where up to 30% of returns have this item missing. There is also the question of the relationship between mental hospital admission rates and true incidence and prevalence rates. It is safe to say that psychiatric hospital admission rates are an under-representation of true rates, with many cases not coming to the attention of psychiatric services at all. In addition a large number are dealt with at outpatient clinics and by GPs.

Whilst it remains important to highlight the deficiencies in these studies, they are useful in one sense, namely that they highlight an under utilisation of formal psychiatric services by the South Asian community. This has led to a number of claims and assumptions as to why the South Asian community do not use the psychiatric services which can be summarised as follows:

Selective Immigration

The positive selection hypothesis suggests that only the healthiest individuals from the Indian subcontinent migrated to Britain (Cochrane and Bal, 1989). However as Mahmud (1987) points out, no research validation has been published to indicate whether immigrants are negatively or positively selected in comparison to non-immigrants remaining in their country of origin.

Asian Specific 'Cultural' Factors

The stigma of mental illness within the South Asian community may result in South Asian families not wanting any mental illness brought into the open for fear of the social disgrace (Littlewood and Lipsedge 1989; Rack' 1982; 1985). Schofield (1981) suggests that this can be partly traced to the standing of psychiatric services in the Indian subcontinent and points to the low status of psychiatry in medicine there. Psychiatric services in countries like India and Pakistan can often be of a very basic standard (Schofield, 1981). In many parts of the subcontinent nobody goes to see a psychiatrist unless they are 'mad', and no one is designated 'mad' unless they are violent. A person who is mentally disturbed but not violent is not perceived as 'mad'. Henley (1979) points out that all degrees of mental illness are referred to by the word *pagal* meaning insane. The link between madness and violence affects the nature of hospitals with custodial care the only intention, ECT the usual treatment, compulsory detention the norm and discharges the exception (Rack, 1982). Rack believes that where this description is no longer true, it probably was within living memory. Not surprisingly mental hospitals are often viewed with trepidation by South Asians from the subcontinent (Rack, 1982).

It has been suggested that mental illness may be managed within the South Asian family, and treatment-seeking inhibited, until the condition becomes well advanced (Schofield, 1981; Cochrane, 1983). The tendency of South Asian patients to focus on bodily complaints has been noted (Rack, 1982; 1985; Bal, 1987), with the result that GPs often miss cases of depression in South Asians. Ideas of psychological explanations of mental illness appear to be poorly understood (Skultans, 1986). Leff (1973) suggests that cultures which place a strong emphasis on the importance of the individual rather than on the group may be more conducive to the development of a sense of personal identity. In South Asian cultures unhappiness and depression are often viewed as conditions to be borne fatalistically, not as an illness for which a cure might be sought (Ineichen, 1987).

British Asians are regarded as being more likely to present somatically with a depressive illness, with the possibility and often probability they will be misdiagnosed by doctors. A study of 100 patients (50 Asian, 50 English) at four general practices in Birmingham would seem to add support to this view (Bal, 1987). Individual health beliefs are culturally determined and the way an individual explains his or her illness is strongly related to ethnocultural health beliefs influencing illness presentation, illness behaviour and help seeking behaviour (Nations et al., 1985).

Littlewood and Lipsedge (1989) posed the question; can we say depression exists without it being recognised by name? For them one solution is to see if there is a bodily change in a depressive-like illness which can be measured in different communities without needing to use specific words. We could then see how this overlaps with culturally recognised states in different languages. According to Littlewood and Lipsedge we do find a pattern of physical symptoms in depression: sleep disturbances such as waking early in the morning, constipation, loss of energy and lassitude, difficulty in concentrating, loss of appetite and decreased sexual desire. The question is the presentation of such symptoms.

Fernando (1987) develops this point in relation to what he claims is a definition of depression that is ethnocentric to western European culture. The long standing emphasis on a mind-body dichotomy and a recent pre-eminence of mental feelings over bodily ones have resulted in what he terms a totally "psychologised" concept of depression. In Fernando's opinion if we de-codify this disturbance and accept it as a cross cultural entity where the total person is affected, the problem of diagnosis disappears. In other words low self esteem, helplessness etc. apply to all aspects of a whole person not just the mind or body. It would appear therefore that the difficulties and misconceptions with respect to depression arise when, because of cultural leanings, the therapist or diagnostician does not look carefully enough into the patient as a person, but instead uses a symptom inventory as a basis for diagnosis and treatment. In such an instance symptoms and behaviour patterns may not add up to give the typical ("western") picture of depression. A misdiagnosis may then result, the problem going unrecorded and untreated.

Does this problem apply to second generation British South Asians, given that they are more integrated into British lifestyles than their parents? A study in 1990 on referral patterns of different ethnic groups to psychiatric hospitals in England and Wales highlighted differences in referral patterns between younger and older South Asians (Bowl and Barnes, 1991). Young South Asians had a higher admission rate than did South Asians overall, and there was a very high proportion of informal admissions among young South Asian women. The findings of the study revealed that in the over-35 age group informal admissions were 14.3% for men and 18.2% for women. The rate for those in the over-35 age group who sought alternative care was 17.1% for South Asian men and 18.2% for South Asian women. Among the under-35 age group, the rate of informal admission to psychiatric services was 12.8% for men and 27.3% for women. The figures for those seeking alternative care in the under-35 age group was 10.6% for South Asian men and 9.1% for South Asian women. These findings suggest that younger south Asians, especially women, are more likely than their older counterparts to go through the official psychiatric services when seeking help for a mental health problem. This could represent an increasing understanding, awareness and recognition of mental health problems among younger South Asian people and a preparedness to seek help from statutory services. The older group on the other hand, are more likely to seek help from alternative forms of care. Berry and Kinshar (1992), following their study on acculturative stress among Indian migrants to the United States, found that immigrants who wished to have no contact with the host society and retain intact their own cultural traditions exhibited psychosomatic stress symptoms, whereas those with regular contact with the host culture exhibited psychological stress symptoms. Berry and Kinshar speculate that those with an assimilatory approach adopted western values of internalising stress and therefore show mental stress symptoms. On the other hand, those whose attitudes were still closely tied to the Indian culture, where it is acceptable to vocalise and externalise stress symptoms via physical complaints, did exactly that: i.e., in the manner they would have done in their country of origin.

Whilst the cultural argument regarding the presentation of mental illnesses such as depression in non-indigenous and culturally different populations is I believe a valid one, does this necessarily apply to second generation South Asians, socialised in Britain? On the basis of their being

socialised in Britain and recalling the findings of Bowl and Barnes (1991), one could speculate that recognition and presentation of mental illness could be similar to the white indigenous population. Evidence for this standpoint is strengthened by citing a study by Howlett et al. (1992). This study was an investigation of white, South Asian and Afro-Caribbean peoples' concepts of health and illness causation which found that South Asians gave similar responses to the other groups to questions as to whether worry, stress and tension are causes of depression (54% South Asian, 51% white, 58% Afro-Caribbean). Other studies have also reported that South Asians acknowledge worry and stress to be significant factors in mental illness (Donovan, 1984).

Alternative Healers.

South Asian patients may side-step conventional medical services and prefer to approach hakims or other alternative healers. Ineichen (1990) claims there is little evidence this happens on a major scale but until there is a valid study of this issue, I would not like to speculate on the strength of such a claim made by either side.

Lack of South Asian Specific Health Programmes.

Studies which highlight the use of services geared to the South Asian community indicate that usage among this group is considerably higher than statutory services which offer no such provisions. A survey of mental health provision in the borough of Newham (Wills, 1990) showed that in several of the facilities in the health sector South Asians were underrepresented relative to the size of the South Asian population in Newham. One the other hand, within the voluntary sector the reverse was sometimes the case. For example, the Newham branch of National Association of Mental Health (MIND), which offers a specific service to South Asian women, reported that 39% of its clients were South Asians (compared with an estimated South Asian population in the borough of only 13%). A project undertaken to investigate the problems of London's South Asian community which involved a phone-in counselling service through a local radio station showed that the main health concerns expressed were not those currently catered for by health education programmes. The top five listed complaints included all mental health problems ranging from mild depression to those receiving hospital treatment (Webb, 1981).

Factors relating to GP Services.

At first sight, paradoxically, insensitivity to the needs of South Asian people within mental health services was seen to contribute to their low referral rate (Bowl and Barnes, 1991). Brewin (1980) speculated that the reason psychiatric referrals and hospitalisation among South Asians remained low was because GPs failed to recognise the symptoms of mental illness among patients from a different culture. Hitch and Clegg (1980) contend that South Asian patients can fail to communicate with their doctor in a manner which enables him to 'read the signs' of mental illness. Ineichen (1987) points out that the ethnicity of the GP has received little attention. The nationality of the GP appears important for some South Asian patients, notably those from rural backgrounds (Jain et al.., 1985). Cartwright and Anderson (1981) drew attention to the fact that GPs trained in the Indian sub-continent (who can often have a high proportion of South Asian patients) are less likely to feel it appropriate for patients to consult them with problems related to family life and may discourage their patients, directly or indirectly, from attending to such problems.

Currer (1986) states that while the incidence of conditions such as depression is probably high amongst South Asian women, contact with psychiatric services and hospitalisation rates remain low. This view is backed up by Schofield (1981) who quotes a community worker involved with South Asians: *"we have no accurate figures available but I know that depression is growing amongst South Asians especially the women and the old. We are constantly seeing cases of isolated, depressed people.... these women get so miserable they become mummified, apathetic and depressed"* (Schofield 1981). Finally Ineichen (1990) believes that although British South Asians may show low rates of mental illness and a tendency to under-report mental illness, their prevalence of mental illness will probably gradually reach national levels, both overall and for particular diagnoses.

What can be taken from this overview? Given the findings of Bowl and Barnes's (1991) study regarding differences in admission rates, Howlett's (1992) findings of awareness in the South Asian community of factors affecting mental health, and the observations of Currer (1986) and

Schofield (1981), we can say that mental illnesses such as depression do exist within the South Asian community and at a higher rate than official statistics suggest. In addition, there appears to be a growing understanding and awareness of mental disorder as well as a preparedness to seek help for mental health conditions, especially among younger South Asians. The deficiencies in our mental health services, however, can make obtaining appropriate support and treatment difficult (Webb-Johnson, 1991). What can also be gleamed from this overview is that women are more likely to experience, and/or seek help for certain disorders. The next section will look in detail at the mental health of South Asian women.

The Mental Health of South Asian Women.

As with the indigenous population, a wide variety of mental health problems exist within the South Asian community. These include depression, anxiety, eating disorders and various psychotic disorders (Littlewood and Lipsedge, 1989; Fernando, 1990). These conditions, however, may be experienced and manifested differently in sections of the South Asian community when compared with the majority white indigenous population. Over recent years a number of studies have focused on the apparent increase in deliberate self-poisoning among young South Asian women and the higher rates of such actions when compared with white indigenous women of the same age group.

Self-poisoning in South Asian Women

The study of suicide has received much attention and has a wide literature. In relation to such deliberate self-harm, the term 'attempted suicide' was frequently applied. Kessel (1965) and Kreitman (1969) proposed that the term 'attempted suicide' was unsatisfactory as the great majority of patients so designated were not in fact attempting suicide. Kessel (1965) contended that the term 'attempted suicide' should be replaced by 'deliberate self-poisoning' on the grounds that the patients performed their acts in the belief that they would survive their overdose and be able to disclose what they had done in time to ensure their rescue. Kreitman (1969) proposed the adoption of the term 'parasuicide', which he defined as any individual who deliberately initiates an act of non-fatal injury or who injects a substance in excess of any prescribed or generally recognised dose that did not involve ultimate intention. In his study of parasuicide in young Edinburgh women,

Kreitman (1977) found an increasing rate of parasuicide among married teenagers, notably those in debt and who were victims of violence. On a general level, the rates of parasuicide or deliberate self-poisoning are much higher than those for suicide, the diverging trends substantiating the claim that these two forms of suicidal behaviour are distinct and likely to have different aetiologies. Studies do indicate, however, that parasuicides are a very high risk group for eventual suicide. A number of studies have described factors which appear significant in determining deliberate self-poisoning. These include antagonistic family situations, depressed mood, personal experiences of significant loss, and intra-familial violence (Kosky, 1983; Taylor and Stansfield, 1984; Kerfoot, 1988).

In a study of ethnic differences in self-poisoning comparing South Asian and white groups, Merrill and Owens (1986) found a number of significant differences between the two groups. Marital problems were more often complained about by South Asian women than by white married women (South Asians 72%, whites 49%). The complaints were frequently attributed to arranged marriages that were never wanted, husbands demanding their wives behave in a less Westernised fashion, and South Asian mother-in-laws interfering in the way they ran their life and marriage. According to Merrill et al.., 'culture conflict' was found to be present in the situation of 61% of unmarried South Asian females. The women complained that their families were imposing what they saw as restrictive South Asian customs which included arranging marriages, not allowing them to go out at night, mix with boys or go on to further education. Marital problems seem to be particularly common when the wife has recently migrated and has to contend with life in an alien culture in addition to living with a new husband and family. It should be noted that adolescent rebellion is the norm in most cultures and is commonly implicated in self-poisoning amongst whites. In addition, marriages can go wrong for a number of reasons and if arranged there can be a tendency to blame that as the sole reason (Merrill and Owens, 1986). Whilst acknowledging this, recent data has shown that over the last five years the incidence of reported self-poisoning appears to be on the increase among South Asian women. Admissions to hospital of South Asian female 'self-poisoners' under 35 years for the years 1985-1986 was 33% higher than for 1978-1979. This

increase is in marked contrast to the fall of 33% in admissions of white females of similar age over the same period (Merrill, 1989).

In a further study in this area, Merrill (1989) highlights that South Asian women scored significantly higher on Beck's Suicide Intent (SIS) and Hopelessness Scales (HS) with those whose marital status was 'separated' recording especially high scores. Hopelessness is known to be a significant factor in depression. A measure of traditionalism and inter-generational conflict of values, the Traditional Values Scale (TVS) was also administered. A positive correlation was found for non-traditionalism, conflict, SIS and HS scores. The research team also administered the General Health Questionnaire (GHQ), HS and TVS to fifth form students at two Birmingham Schools. GHQ scores and HS scores were significantly higher for South Asian females than other groups and were highly correlated with scores of non-traditionalism and conflict on TVS. Mumford (1991) notes that a previous study in Birmingham found that the rates among South Asians were lower than among Caucasian students (Burke 1976), and states that this increase in the rate of self-poisoning suggests both an increasing adoption of western patterns of reacting to stress and also high levels of distress in these young South Asian women.

In a study of South Asian adolescents in Coventry, Handy et al.. (1991) identified intergenerational culture conflict over dress, religious attitudes, and relationships outwith the family as major precipitating factors in South Asian female 'self-poisoners'. Kingsbury (1994) in a study of psychological and social characteristics of South Asian and white adolescent overdoses in Britain found that South Asians were more socially isolated than their white peers and that despite having lower suicidal intent, South Asians had higher rates of depression, hopelessness and previous overdose. Parental relationships in South Asians were more controlling, and more problems were reported with parents compared with whites.

Eating Disorders in South Asian Women

Over the last five or six years studies have identified eating disorders in South Asian women, disorders which were previously believed to exist only among 'western' women. In a study of eating disorders among South Asian schoolgirls in Bradford (Mumford et al.. 1991b), a higher percentage of South Asian girls compared to Caucasian girls met DSM-III-R criteria for bulimia nervosa. It is believed that anorexia nervosa and bulimia nervosa are uncommon among non-western societies and among non-Caucasians in the western world. Of the hypothesis put forward to explain the rarity of anorexia nervosa in non-western cultures, the most likely one appears to be that these cultures value a clear body shape much less than western, white cultures (Nasser, 1988). Reviewing the research into the relationship between these syndromes and culture, Nasser (1988) concluded that adoption of western cultural values by other societies is associated with the emergence of similar syndromes in their cultures.

Furnham and Alibhai (1983) compared the perceptions of body shape in three groups of females of different ethnic origin. They found that the perceptions of body image in the South Asian group were similar to those of the indigenous British females. Mumford and Whitehouse (1988) found distorted eating behaviour to be unexpectedly common in young British South Asians aged 14-16 who grew up with western notions of slimness and dieting preoccupations. In relation to Mumford's 1991 study, there were three aims: (a) to assess the validity of the Eating Attitudes Test (EAT) and the Body Shape Questionnaire (BSQ) when used with South Asian schoolgirls, (b) to estimate prevalence of anorexia nervosa and bulimia nervosa among South Asian and Caucasian schoolgirls in Bradford; and (c) to identify the social and cultural factors which correlate with high scores on the questionnaires and with diagnosed eating disorders. Among the South Asians, the high prevalence of bulimia nervosa in this survey (3.4%) was unexpected. Their results in this group (mostly Pakistani Muslims) suggest that eating disorders may be common among South Asian girls in the UK.

It is not known how common eating disorders are across the Indian subcontinent. Mumford et al.. (1991b) believe that their prevalence is probably quite low and, on the basis of private conversations with psychiatrists in several Indian cities, indicates that sporadic cases of anorexia nervosa occur among Western-oriented social groups. Mumford et al.. (1991b) speculate (without adequate baseline data) that the high prevalence of bulimia nervosa among South Asian girls in the UK is a new phenomenon in these families. Furthermore, it is probable that these South Asian girls are increasingly adopting 'Western' patterns of reacting to personal conflicts and stressful life circumstances. They add "*there is a parallel to our findings from the studies of the parasuicide rate among ethnic minorities in Britain*" and point to the findings of Merrill and Owens (1986) of a greater rate of self-poisoning among young South Asian women compared with indigenous white women.

It is interesting to note the findings of Mumford et al.. (1991b) that the South Asian girls who made greatest use of South Asian language and dress had the highest mean scores on both EAT and BSQ. The use of English in the home and consumption of Western food showed no relationship with the questionnaire scores. Moreover, those South Asian girls diagnosed as bulimic had significantly higher 'traditional' scores than the rest of the South Asian girls; their 'Western' scores were not significantly different. (In an attempt to measure the 'Western' and 'traditional' cultural orientation of each South Asian girl, four questions concerned with language, dress and food were devised). Various explanations were advanced to account for these results. They can be summarised as follows: (a) the most traditional girls may be experiencing the greatest internal conflict e.g. around issues of identity as they grow up with two sets of cultural values; (b) it may be the greater the difference between the two cultures, the greater the internal conflicts and anxieties which arise; (c) greater rigidity of family functioning within traditional families may lead to greater inter-generational conflict (widely held to be an aetiological factor in western anorexics, Mumford et al.,1991b).

The use of the Eating Attitude Test across different cultures has its critics. Lee (1991) contends that eating and attitudes to body shape vary greatly and anorexic patients from different cultures may

manifest different patterns. He believes the use of western instruments to assess eating attitude and body image is fraught with controversy, not least with respect to linguistic and conceptual problems which might lead to misinterpretation of the Eating Attitude Test.

The closest parallel to the findings of Mumford et al.. (1991b) was two studies in Kuwait on the relationship between inter-generational conflict and psychiatric symptoms (El-Islam et al. 1986, 1988). There were similarities between modern Kuwait and the Pakistani Muslim community of Bradford (88% of Mumford's sample), i.e., a conservative Muslim society experiencing rapid social change by reason of exposure to Western attitudes and values (Mumford et al.. 1991b). El-Islam et al.. found a trend towards an increased number of psychiatric symptoms (as measured by the 28-item GHQ in Árabic) in connection with the greater difference in cultural attitudes between parents and children. Such a relationship was not present between symptoms and 'liberal' attitudes. For El-Islam, it is the conflict of attitudes, rather than the adoption of non-traditional attitudes as such, that is likely to be linked to psychiatric symptoms.

Citing previous work from his clinical experience, El-Islam (1983) states that the inter-generational conflicts focus, in the main, around patterns of family relationship, methods of marriage and the emancipation of women. A summary of the explanations of Arab commentators for these conflicts is given by El-Islam. The reasons put forward were: parental attempts to direct children in accordance with parents' aspirations rather than their own interests, exposure to Western influences, adoption of more progressive values by the young and rigidity or loosening of parental control.

These themes figured prominently among Muslim young women who were referred to the psychiatric services in Bradford with neurotic disorders. In stating this, Mumford et al.. (1991b) believe it is probable that increased prevalence of eating disorders among South Asian girls surveyed is just one indicator of hidden conflicts and distress experienced by many South Asian girls growing up in Britain who have traditional families.

A study of anorexia nervosa in young South Asian children over a three year period (Bryant-Waugh and Lask 1991) revealed that 4 (13%) of 30 successive referrals of girls with anorexia nervosa were of South Asian origin. All fulfilled both DSM-III (American Psychiatric Association 1980) criteria for anorexia nervosa. In all cases 'culture conflicts' in the form of domestic expectations, use of leisure time and choice of dress were present. Bryant-Waugh and Lask (1991) noted that none of the children's families had exchanged their traditional culture for a more typical Western lifestyle. They speculate that the more 'traditional' the family, arguably the greater the possibility of sociocultural conflict around such issues as arranged marriages, norms regarding dress and contact with the opposite sex, the role of females and mealtimes and cooking.

Anorexia nervosa has often been linked with the difficulties generated by the developmental demands of adolescence. Crisp (1980) views anorexia nervosa as essentially a psychological disorder resulting from an avoidance of adolescence, a well known example of such a developmental theory. It is widely acknowledged that the tasks of adolescence, which include the formation of an integrated sense of self, can be problematic for many young people. Bryant-Waugh and Lask (1991) argue that the issues of autonomy, control and sexuality may present particular difficulties for South Asian girls described in their study. On the basis that norms and social rules regarding such issues are largely culturally determined, one can see how young people growing up in an environment of two differing cultures may experience ambivalence. This, in turn, may make them more prone to the development of eating disorders, a process often linked to uncertainty regarding the individual's sense of self (e.g. Bruch, 1973). In the field of anorexia nervosa research, DiNichola (1990) has put forward the transcultural hypothesis that anorexia nervosa can be seen as a 'culture change syndrome' whose onset may be induced under conditions of 'sociocultural flux'. He refers to case examples reported by Bulik (1987) and Kope and Sack (1987) which support this view, and demonstrate that stresses related to immigration and acculturation can possibly result in the development of eating disorders in populations not previously considered a risk. Bryant-Waugh and Lask (1991) suggest that the alternative influences to which South Asian children are exposed, with the resulting inter-cultural and inter-family conflicts, may act as added stress factors contributing to the development of anorexia nervosa.

Following their retrospective study on eating disorders in Nottingham, Bendall et al.. (1991) stated that anorexia nervosa was present with young South Asian girls (16 years and below) who had "problems originating from family distress, especially poor marital relationships, unemployment, isolation and social problems in extended families" and with older girls aged over 16 years problems related to "culture clashes including emancipation of women". They concluded that eating disorders in older girls developed when "traditional family attitudes clash with more personalised western ones, especially over 'female' roles and marriages (Bedall et al., 1991:441).

Depression in South Asian Women

Research carried out among South Asian communities indicates that the most common mental illness found among South Asian women is depression. These findings concur with the experiences of health and welfare professionals working among the South Asian community (Hitch and Khan, 1980; Khan, 1983; Beliappa, 1991). Depression may be caused by a wide range of combining factors. Many of these factors are related to marital and family relationships, socio-economic status and racism (Littlewood and Lipsedge 1989; Fernando 1990; Beliappa, 1991). Available evidence points to an increasing uncovering of mental distress amongst South Asian women, particularly young women, which has been linked to social isolation and conflict over expected roles (Khan, 1983; Jervis, 1986; Merrill et al., 1990; Beliappa, 1991).

One of the most in-depth studies conducted into depression among British South Asian women was by Fenton and Sadiq (1993). This study was aimed at exploring the extent to which cultural differences affect the experience of depression as a form of mental illness and to the extent to which depression might be regarded as a western medical construct. It aimed to reveal the language women used to describe their emotional and mental distress and to identify precipitating and vulnerability factors of depression in the women's lives. A list of eight common symptoms characteristically associated with depression was drawn up: sleeplessness, physical weakness, inability to cope with daily tasks, loss of appetite, sense of worthlessness, loss of meaning in life,

tearfulness and suicidal thoughts. With regard to length of stay in Britain, some had been in the UK ten years or more, others were quite recently arrived.

The main findings of the study were;

(i) All the above symptoms of depression were consistently reported and volunteered by the women themselves. None of the sixteen women mentioned less than five of these and the majority included all eight in their stories.

(ii) The chief precipitating factors to the women's problems were bereavement and interpersonal (usually intra-family) disputes. The chief exacerbating and vulnerability factors were sheer material hardship, evident in housing, employment and financial difficulties; social isolation, including the absence of anyone to talk to on intimate terms; difficulties with child-care; and racial hostility and abuse.

(iii) Fenton and Sadiq (1990) concluded that South Asian women experience that syndrome of thoughts and feelings which are very much akin to that which English speakers describe as depression. In addition, they regarded this disorder as illness of the mind. They were also able to make the connection between mind and body and to understand the interaction between physical and psychological problems.

(iv) In relation to whether they viewed this illness as treatable by a doctor, there was a mixed response. Expectations of western medicine played a role in determining the nature of the symptoms presented to the GP. Fenton and Sadiq (1990) postulate that physical symptoms may have been presented not as a result of a lack of understanding of the connection to the psyche but because of the perception that these conditions are treatable by a fundamentally 'physical' medicine.

Beliappa (1991) following a study of South Asian women in London revealed that depression may be caused by a wide range of combining factors. Within the South Asian community many of these factors are related to marital and family relationships, and socio-economic conditions such as housing, employment, poor economic status and racism. Beliappa (1991) found that fulfilment of expected roles was an important factor in determining how an individual assessed herself. A significant number felt unable to reach expectations associated with their roles, or else felt there was little scope for challenge and independence within circumscribed roles so that they became repetitive and unmotivating. This was especially the case where little reward or appreciation was forthcoming. Low self-esteem resulted from inability to fulfil expected roles or loss of meaning associated with roles. Additionally, in a situation in which an individual was experiencing abuse from her partner, self esteem was reported to be low.

What is Depression?

The review of studies carried out into mental illness within the South Asian community suggests that depression is the most common mental health problem. Although depression will be addressed in a separate chapter, a brief comment may be useful at this stage. In everyday usage, depression often refers to a negative emotional state. There is little concern for concomitant changes in self-esteem, level of activity, interest, or shifts in ability to meet usual role expectations. When lay people use the term, they are usually referring to misery and despair. In psychiatry depression carries a two-fold connotation. First, depression can be classified as a state, trait or symptom occurring as a secondary complication in a diversity of physical and mental disorders. Alternatively it can be a clinical pathological entity in its own right, implying a reduction in hedonic activity, loss of interest, and a reduction in one's sense of competence all in a context of dysphoric mood state (Furnham and Kuyken, 1991).

The emerging consensus is that depressive phenomena are multifactorial in origin resulting from the lifelong interaction of a number of factors. For example, status attributes such as gender, education, marital status, employment, income and ethnicity have all been implicated as having aetiological significance (Dohrenwend, 1974; Brown and Harris,1978). Personal resources or

limitations reflected in other measures of psychological state, coping, social support or social connections have also been considered in previous studies (Mueller, 1980). Life event stresses associated with acute events or chronic situations requiring adaptive changes are also thought to be important factors in the chain of events leading to depression (Dohrenwend, 1978). Several reviews point out that the risk of depression is greater for women, for the young, the poor, and for the separated or divorced. A great deal of attention has been paid to the role of social connection and social support in the epidemiology of depression (Brown and Harris, 1978), and the evidence indicates an important role for such factors.

Attention has been drawn to the fact that British Asians are at particular risk from heart disease, more so than native British people. A survey conducted in 1988 shows 20% more Asian men and 30% more Asian women die of coronary heart disease than British people of non-Asian origin. Classic risk factors such as unhealthy diet and smoking have been discounted and one theory is that Asians are at a much higher risk because of very long hours worked in cramped conditions, the continual irritant of racism and the trauma involved in transition from one culture to another (Joffe, 1989). The question of racism almost inevitably arises in any discussions on mental illness in ethnic minority groups and Fernando (1987; 1990), is one of many who believe that racism is a major factor in the development of depression in British South Asians.

Racism and Depression

Evidence from various surveys suggests that racial inequalities persist in Britain in many respects from education to employment, housing and health status. The combined impact of lower job status, unemployment, poor and overcrowded living conditions with fewer basic amenities, are important when considering factors that affect the mental health of Asians living in Britain (Pearson, 1989). The Black report of 1982 found that median weekly earnings for Asian men were lower than for white men. Most Asians live in inner cities where housing is poor. According to the Policy Studies Institute (PSI) survey of 1982, 44% of Asian households in innercities had more than one person per room, compared with only 1% of the white population. Household size and structure affect mental health. Overcrowding as well as isolation can affect mental health,

generating stresses which may pre-dispose people to mental ill-health (Pearson, 1989). In relation to social class position, most Asians are at the lower end of the scale. Most studies have indicated a greater risk of mental disorder at the lower end of the social class scale (Kessler, 1982). Fenton (1986) has pointed to racial hostility, as a source of stress which can be a provoking factor in mental ill-health. Most obvious are direct abuse and threats but also structural discrimination. There exists a wide body of literature which states that racial discrimination must be recognised as a factor when discussing provoking agents in the development of psychiatric disorders in South Asians (Rack 1985; Burke 1984; Fernando 1987;1990).

Although racial prejudice is an obvious stress to anyone who experiences it, institutionalised racism is much more than that and its damage is subtly destructive to the individual. Its role in the aetiology of depression can be examined by considering three aspects, namely, self-esteem, sense of loss, sense of helplessness (Fernando, 1987). Saifullah Khan (1982) describes how people living in two or more socio-cultural systems identify with them to different degrees. This synthesis becomes very complicated in a racially biased society where one culture is held to be dominant over another and real power is held by the dominant group.

For Fernando, identity (and adjustment within that identity) is closely related to self-concept and self-esteem. A simplified definition of these phenomenon is that each person forms an individual identity by internalising 'bits' from people within families, culture groups and wider society. The self-concept or self-image is the combination of these - a person's picture of him or herself. A person's evaluation and feelings about self-image are what Coopersmith (1975) called self-esteem. The question of ethnic minority self-esteem and self concept (especially in black and Asian minorities) and their link with depression has been widely researched and debated. There exists a line of argument in some academic quarters which states that because of discrimination on the basis of colour and minority status, such groups experience lower self-esteem and are, therefore, more at risk of developing mental health problems, particularly depression. This is a potentially powerful assertion and one which must be addressed in this thesis. Before addressing this important issue a

brief review of the theories relating to self-esteem and self concept maybe helpful in assessing the strength of these assertions.

Section 2

Self-concept

In the view of Piers (1984) self-concept is defined as a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behaviour and attributes. Rosenberg and Kaplan (1982) state that self-concept is the totality of the individual's thoughts and feelings with reference to himself or herself as an object, an awareness of the type of person one is.

That social influences bear on self-concept formation is generally acknowledged. However, Rosenberg and Kaplan (1982), whilst recognising such influences, state that they do not fully construct the individual. The individual, guided by a powerful system of motives, answers back, coping in a variety of ingenious ways with the forces to which he or she is exposed. These, what Rosenberg and Kaplan call intrapsychic processes, help us to understand why social influences often fail to produce effects which we would, on theoretical grounds, expect. These defence mechanisms are primarily directed towards the protection of self-concept. Having noted their opinion, we should consider the general principles of self-concept formation.

Four principles of self-concept formation deserve special consideration: reflected appraisals, social comparison, self-attribution and psychological centrality.

Reflected Appraisals

The social psychological nature of the self-concept is best illustrated by the principle of reflected appraisals. The principle was most fully elaborated in the work of George Herbert Mead (1934). For Mead, the self-concept was unequivocally a social product, arising out of the process of communication. In order to communicate, Mead stressed, people employ certain gestures, primarily vocal, which become significant symbols. Symbols become significant "*when they implicitly arouse in the individual making them the same responses which they explicitly arouse, or are supposed to arouse, in other individuals, the individuals to whom they are addressed..... the flow of meaning involved depends on (the individual's) taking the attitude of the other toward his own gestures*" (Mead, 1934:47). Such role-taking makes possible adjustment and response among those engaged in the interaction.

In a simplified version of Mead's ideas, two inferences seem clear; (1) we become objects to ourselves, thereby developing a self-concept; and (2) as a consequence of taking the role of the other, we tend to see ourselves from the viewpoint of particular others or the generalised other (Rosenberg and Kaplan 1982).

Social Comparison

Evaluations of the self as clever or stupid, interesting or dull do not take place in a vacuum; they invariably require reference points which serve as bases of comparison. The question of how good we are can only be answered by the question: compared to whom or what? Self-evaluations are thus based heavily on social comparison processes (Festinger, 1954). The idea that we can only judge our worth with reference to some standard is well entrenched in the self-concept literature which frequently measures global self-esteem as the discrepancy between the individual's self-concept and his or her ideal self. Campbell (1984) contends that self, the meaning of self, is the entire you; you in all your aspects and prospects, you in all your identities and identifications.

The social comparison principle has usually been applied to comparisons with other people. Pettigrew (1967) observed that one may judge oneself by comparing oneself to those in one's peer groups (classroom, gang, factory or neighbourhood), to others in the same social categories (to most ten year olds, to most professors, or to most women), to remote reference groups (the upper class, the Christian martyrs), or to a single person. Furthermore, such comparisons may be situational or general.

Self-attribution

This principle essentially rests on the radical behaviourist position of B.F.Skinner which, according to Bem (1967), "*eschews any reference to hypothetical internal processes and seeks, rather, to account for observed functional relations between current stimuli and responses in terms of the individual's past training history.*" (Bem, 1967:184) According to this argument, when we attribute traits or other internal states to other people, what we are actually doing is applying terms

to certain behaviour occurring under certain circumstances on the basis of our past learning. Bem advances the idea that people draw conclusions about themselves on the same bases. Individuals come to 'know' their own attitudes, emotions and other internal states partially by inferring them from observations of their own overt behaviour and/or the circumstances in which this behaviour occurs (Bem, 1972). Thus, the man who, after consuming a huge meal, concludes that "I guess I was hungrier than I thought" is drawing conclusions about his state of hunger not on the basis of his own physiological experience but on the basis of his observed behaviour. For Rosenberg and Kaplan (1982), we conclude that we are intelligent in that we characteristically get the right answers or do well on tests and that we have good manual skills when we successfully repair an object. Our own actions teach us new things about ourselves, modifying our self-concepts. After engaging in these activities for the first time, we discover that we have a particular talent. The self-concept influences behaviour; however behaviour (or its consequences) also influences the self-concept.

Psychological Centrality

The principle of psychological centrality rests on the proposition that the self-concept is a structure whose diverse components have unequal salience and importance. Some dispositions are central to the individual feeling of worth, whereas others are peripheral. Some people pride themselves in their attractiveness and care little about their literary skill; for others the reverse is the case. It thus follows that if we are to understand what differences a particular self-concept component makes for one's global feeling of worth, we must know not simply how one evaluates oneself in that regard but also how much importance one attaches to it.

Self-esteem

Thus, the greater a person's success in achieving whatever it is they desire, the higher their self-esteem. Unless, of course, their pretensions increase accordingly, in which case their self-esteem would not increase. By pretensions we mean what we back ourselves to be and do, our supposed potentialities. This seems to correspond with what many writers refer to as our "ideal self-image" or "ideal self-concept" (Rosenberg and Kaplan, 1982). Self-esteem is an important variable in

assessing mental health, particularly depression. What is self-esteem? A common theme when referring to self-esteem is an awareness of possessions of desirable qualities or qualities by oneself, with desirable objects meaning anything that particular individual considers desirable. William James, the pioneering American psychologist, used a much quoted formula with regard to self-esteem:

$$\text{SELF-ESTEEM} = \frac{\text{SUCCESS}}{\text{PRETENSIONS}}$$

Arthur Cohen (1968) states that self-esteem may be defined as the degree of correspondence between an individual's ideal and actual concepts of himself. Cohen's formula, like that of James, is for level of self-esteem. His definition also indicates that self-esteem can be raised either by elevating one's actual self-concept or by scaling down one's ideal self-concept.

Coopersmith (1967), sees self-esteem as the evaluation which individuals make and customarily maintain with regard to themselves: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy. In short, self-esteem is a "*personal judgement of worthiness that is expressed in the attitudes the individual has towards himself*" (Coopersmith, 1967:4-5). When we speak of high self-esteem, then, we shall simply mean that the individual respects him/herself; considers him/herself worthy; he/she does not necessarily consider him/herself better than others, on the contrary, recognises limitations and expect to grow and improve. Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, self-contempt. The individual lacks respect for the self he/she observes. The self-picture is disagreeable and they wish it were otherwise. These definitions appear to have a common theme which is basic to our use of the term: high self-esteem consists of favourable perceptions and evaluations of oneself.

Self-esteem is not a fixed entity, however. A person may have high self-esteem in some aspects of his or her life and low-self-esteem in other aspects. Although a person's self-esteem is subject to

fluctuations, it seems realistic to speak of a general level of self-esteem that is characteristic of each individual. The customary level of self-esteem characteristic of an individual is referred to as his or her "global self-esteem" (Campbell, 1984). High self-esteem is mental health. Self-esteem is happiness. These axioms are the message of numerous popular books today and in a general context, according to Campbell, research appears to back this up.

For Campbell (1984), self-esteem is awareness of goods possessed by the self. Therefore any goods possessed by the self are factors contributing to self-esteem. This goes for goods a person thinks he/she possesses but doesn't. Thus, helping to increase or maintain self-esteem is any good, actual or potential, that one can consider one's own. Good is taken to mean "anything desired" for example; ancestry, nationality, achievements, talents, friends, loved ones, social status, attention and acceptance and love from others.

Coopersmith (1967) groups the conditions and experiences that seem to be associated with self-esteem into three categories: success, values and aspirations, and defences. Success has four elements: (I) power - the ability to influence and control others; (ii) significance - the attention, acceptance and affection from others; (iii) virtue - the adherence to moral and ethical standards; and (iv) competence - successful achievement. Whatever successes the individual has or thinks he/she has in any of these areas enhances self-esteem. By defences Coopersmith means the individual's strategy and ingenuity in interpreting his experiences in such a way as to maintain or enhance his self-esteem. These strategies include, but are still broader than, the standard defence mechanisms. Summing up, Coppersmith says we enhance our awareness of good possessed not only by acquiring more good, but also by juggling our subjective attitudes, that is, by value shifts and defences. The nature of good as "anything desired" opens another possibility for enhancing or preserving self-esteem. This is the method of adapting our aspirations, ambitions and pretensions to what is most feasible considering our circumstances. In effect, adjusting our definition of desirable to suit our situation (Campbell, 1984).

It would appear however that having hope and ambition can, on occasion, be a double edged sword: having high ambitions can give us a lift while we still entertain hopes of fulfilling them. But, as Coopersmith and James point out, when we fail to achieve our goals, the gap between aspirations and success, between actuality and ideal self-image, lowers our self-esteem.

For Campbell (1984), most significant in the consideration of self-esteem sources is the dichotomy between other-dependent sources and self-dependent sources. Other-dependent sources of self-esteem are the manifestations of esteem that others give us - for example, acceptance, praise, friendship, respect, love, etc. Self-dependent sources are those which are relatively independent of what others think of us. Among these are intelligence, strength, talents, ancestry, wealth, living up to one's own ethical code, ambitions, etc. This dichotomy was emphasised, among others, by Silverberg (1952), who terms these two variables "inner" and "outer" sources. A stable self-esteem depends on development of "inner sources". Both sources, according to Silverberg, are important but "inner source" is the steadier and more dependable; the latter is always more uncertain. In a neat summary Silverberg comments "unhappy and insecure is the man who, lacking an inner source for self-esteem, must depend for this almost wholly upon external sources".

For many, insufficient development of internal self-esteem, with corresponding over-reliance upon external narcissistic supplies, is conducive to a variety of psychological problems. Developing inner sources of self-esteem adds stability to one's emotional life and is the key to increased psychological freedom and security (Campbell, 1984). Otto Fenichel (1949) developed the theme that loss of self-esteem in depression may be due to loss of social approval ("external supplies") or failure to live up to one's own ideals ("internal supplies"). For Fenichel, depression was depressed self-esteem. Campbell (1984) and others believe that any loss can trigger depression - money, love, prestige, health, disparagement of a set of values espoused by the subject. It is recognised, however, that it does not follow that any loss or set-back will automatically produce depression. As we know other factors are involved. Having established the theoretical basis of these two principles, why are they believed to be important in understanding mental health problems in minority groups?

The Concepts of Self-Esteem and Self-Concept with regard to Ethnic Minorities

Early research has suggested that black children in Britain and the USA had negative evaluations of their self-image (i.e., low self-esteem) and an insecure sense of identity which can be explained by the fact that black children had a black cultural identity, but incorporated the negative feelings towards that identity which are prevalent in white society. In other words the devaluation of a person's culture is incorporated to give low self-esteem (Fernando 1987). The concept of loss is linked with Fernando's points regarding racism and depression. Since we live in a society which promotes the expectation of achievement in terms of merit, if a person expects to get something valuable and then does not do so the result is often anger and/or a sense of loss.

Clearly, such a loss is more likely in a subtly racist society. In lay terms, a loss of this type is more than a setback, it can often lead to a crisis of confidence or a breakdown in personal security. A number of researchers have postulated that depression is the ego's shocking awareness of its helplessness in regard to its aspirations. Many people from black and ethnic minorities do not recognise the racist source of impediments to their achievement. However when they do, the feeling of helplessness could be overwhelming. In this sense racism is a provoking factor in causing depression (Fernando, 1987). In a similar vein differences in the extent of depressive symptoms were explored in a sample of university students from six different ethnic backgrounds. Ethnic and sex differences in the self-reported strength of depression symptoms, as measured by the Beck Depression Inventory (BDI), were found. Students from South Asian ethnic backgrounds scored higher on the BDI and were also more likely to be classifiable as mildly depressed than those from either from East European or Anglo-Celtic backgrounds. An explanation emphasised the role of societal discrimination in producing feelings of learned helplessness and subsequent depression was proposed to account for the ethnic differences in depression symptoms that were observed (Dion and Giordano, 1990).

A great deal of the literature on ethnic minority self-esteem and self-concept, as well as the approach of the actual research, is tied up with the issue of ethnic identity. In order to emerge with an understanding of the key issues relating to ethnic minority self-esteem and self-concept, it would be useful, therefore, to begin with some analysis and comment on what is meant by ethnic identity.

Ethnic Identity

One of the difficulties with the concept of ethnic identity is that of definition. A literature review indicates that ethnic identity is defined in a number of different ways. The fact that there is no widely agreed on definition of ethnic identity is indicative of the confusion surrounding the topic. According to Phinney (1990), about two thirds of the literature on ethnic identity provided no explicit definition of the construct. The definitions that were given reflected quite different understandings or emphases regarding what is meant by ethnic identity. This may be one of the fundamental reasons why much of the literature and research findings on ethnic minority self-concept and self-esteem are inconsistent and contradictory. The term "ethnic identity" is often used interchangeably with "ethnicity" as an umbrella category bringing together such diverse topics as ethnic boundaries, ethnic traits and culture, the ethnic group and ethnic community, ethnic conflict, ethnic labelling, and acculturation and assimilation as well as other processes of sociocultural change among ethnic groups (DeVos and Romanucci-Ross, 1975; Royce, 1982).

In a number of articles, ethnic identity was defined as the ethnic component of social identity, as defined by Tajfel (1981): *" that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership"* (p.225). Some writers considered self-identification the key aspect; others emphasised feelings of belonging and commitment (Singh, 1977; Ting-Toomey, 1981), the sense of shared values and attitudes (White and Burke, 1987), or attitudes towards one's group (e.g., Parham and Helms, 1981). In contrast to the focus of these writers on attitudes and feelings, some definitions emphasised the cultural aspects of ethnic identity: for example, language, behaviour, values, and knowledge of ethnic group history (e.g., Rogler, Cooney and Oritz, 1980).The active role of the individual in developing an ethnic identity was suggested by several

writers who saw it as a dynamic product that is achieved rather than simply given (Hogg et al., 1987; Simic, 1987). In summary, these researchers appeared to share a broad general understanding of ethnic identity, but,the specific aspects that they identified differed widely. These differences are related to the researchers' diversity in conceptualising ethnic identity and in the questions they have sought to answer (Phinney, 1990). Given the volume of literature on this subject area it is surprising that no clear picture has emerged although this may be, in part, because the term often involves a variety of objective and subjective realities as Hunt (1991) claims. Hutnik raises a number of interesting and valid points that merit mention. For Hutnik (1991), the sense of personal identity with the ethnic group and the identification by others as being a member of the ethnic group defines, in part, but only in part, the concept of ethnic identity. The advantage of such a definition over previous definitions that have emphasised cultural similarities and differences is immediately obvious: by focusing on the psychological aspects of ethnic identity (subjective identification, or lack of it, with the ethnic group) it is now possible to embrace the second and third generation, whose overt manifestations of lifestyle may be identical with the dominant group but who may yet maintain varying degrees of identification with the ethnic group. Citing Taylor and Simmard (1979), who define ethnic identity as *"that component of a person's self-definition which is derived from an affiliation with a specific group"*, Hutnik (1991) believes that in the past this process of self-definition in relation to one's group affiliation was an unproblematic issue for the individual. Self-definition was derived directly from what was given at birth: a race; a language; a culture; a tribe; a history of the group's relationship with other groups in society. However, with modernisation, increased mobility and the general modernisation of society, Hutnik believes it is now possible to choose one's ethnic identifications in a self-conscious way. In addition, most people, claims Hutnik, have multiple group affiliations which may be emphasised or minimised according to the situation. Thus, as Wallman (1983) points out, ethnic identity is not a fixed inflexible commitment, steadfast and once and for all. Neither is it necessarily singular: multiple ethnic identities may co-exist. Perhaps, most importantly, ethnic identity is only one of many identity options;

"No-one, not even members of visible (racial) or beleaguered ethnic minority groups, consistently identifies himself or is always identified by others in ethnic terms. Ethnicity is only one identity option ..... and the significance of ethnicity to the individual must be taken into account." (Wallman, 1983; cited in Hutnik, 1991)

For Hutnik, ethnic identity is necessarily an elusive and complex concept, with the term involving a variety of objective and subjective realities. Drawing on her experience of research on Indian families living in Britain, Hutnick states that the family's Indian heritage may be irrelevant to the ethnic minority individual if it is psychologically important for him/her to be British. Also, there may be little or no correspondence between the identity which is psychologically important for the individual and the way he/she is perceived by others: he/she may categorise him/herself as British, whereas in the eyes of others he/she is perceived as Indian. As Chun (1983) points out, individuals continually strive to place themselves in the world of relationships and meanings. The world of relationships and meanings consists, on the one hand, of social relations and, on the other, of persistent existential questions which may encompass social, political and philosophical perplexities. The sense of identity emerges as the individual clarifies for him/herself some of the issues and learns to place him/herself within the total configuration of social relationships and questions related to the nature of being (Chun, 1983). In a similar vein Allen (1983) states that for many people social identity is the most prominent or salient aspect of identity; for others, personal identity is more important. For Weinreich (1977), people do not identify in an all-or-nothing fashion with the values and characteristics of various individuals and groups. They usually identify with some and dissociate themselves from others that is; they form only part identifications with groups and individuals. The above points of Hutnik, Chun, Allen and Weinreich in highlighting the importance of subjective factors in ethnic identity appear to strike a reasonable balance between emphasising the role of objective and subjective factors in ethnic identity and how we are dealing here with a concept that is far from being fixed and readily usable in an ethnic minority context. As Rosenberg and Kaplan (1982) argue:

"A number of erroneous theoretical conclusions, we believe, may stem from the social scientists' tendency to view the situation of the minority group member from the perspective of the broader society rather than from the viewpoint of the minority group member." (p. 213)

A key issue in conceptual writing about ethnic identity has been the role of group identity in the self-concept and self-esteem of ethnic minorities: Specifically, does a strong identification with one's ethnic group promote a positive self-concept or self-esteem? Or, conversely, is identification with an ethnic group that is held in low regard by the dominant group likely to lower one's self-esteem? Furthermore, is it possible to hold negative views about one's own group and yet feel good about oneself?

Ethnic Minority Status and its Effects on Self-Concept and Self-Esteem

Since many ethnic minority groups have been and are victims of prejudice, it has been assumed that low self-esteem may result from ethnic minority status. One major focus of the research has been on Blacks, particularly in America. In the 1960s under the influence of the "mark of oppression" approach, blacks were assumed to internalise negative racial images of themselves with a devastating effect on comprehensive self-esteem. The best-known elaboration of this thesis is the psychoanalytic study by Gardener and Ovesey, *The Mark of Oppression* (1962). Social-psychological role theorists like Pettigrew (1964) reached similar conclusions. The necessity of enacting the role of accommodating, subordinate Negro could not easily be separated from the core self, and lowered self-esteem was the result of this process (though role theorists cautioned that all blacks did not respond in the same manner).

What is the theoretical basis for expecting ethnic minorities to have lower self-esteem? The most obvious is the principle of reflected appraisals (see p.11 above) If Mead (1934) is correct in asserting that we tend to see ourselves from the other's point of view, then group members derogated by society would be expected to develop negative self-attitudes. Furthermore, the damage would probably be worst at precisely the time of life when the individual is most

vulnerable --childhood-- because taunts, name calling, and other attacks are most common at this time.

The second basis for expecting lower self-esteem among minority group members is the social comparison principle, which holds that we judge ourselves by comparing ourselves to others. In a number of socially valued respects, many minority groups compare unfavourably with the majority. These unfavourable comparisons, though stemming from discrimination, may in themselves damage self-esteem. Rosenberg and Kaplan (1982) cite the situation of blacks in American society. Because of discrimination, black socio-economic status is considerably lower than that of white; black children's school achievement scores are, on average, lower than whites; and black children are more likely to come from stigmatised family structures. Thus, not only are black children subject to direct prejudice but also secondary consequences of prejudice and discrimination which issue in unfavourable comparisons with the white majority.

The third theoretical basis for expecting lower self-esteem among minority group members is the self-attribution principle. This principle holds that individuals judge and evaluate themselves as they would judge and evaluate anyone else, on the basis of their overt behaviour or its outcomes. For example, both black and white children generally judge how clever they are by observing their report card grades, test scores and so on. Insofar as minority achievement is lower, the minority child would be expected to judge the self, as others do, less favourably (Rosenberg and Kaplan,1982). Guided by these theories, that minority group members will have lower self-esteem is for some social scientists self-evident. This assumption has been subjected to a great deal of empirical research. What does the research tell us ?

Ethnic Minority Self-Concept and Self-Esteem : Research Findings

Preference Studies

Early research concentrated on ethnic identity and preference from which various conclusions on ethnic minority self-concept and self-esteem were drawn. Most of the research on ethnic identification and preference has used dolls as stimulus material. Clark and Clark (1940) found that the majority preference selections of 'playmate' and 'nice colour' were made by black children in favour of the 'white doll'. Some 33 per cent of black children chose the white doll in response to the question: 'Give me the doll that looks like you'. This misidentification of the self with the white doll stimulated a wide body of research. After reviewing the literature, Brand et al.. (1974, p.883) state that :

"The most consistent finding in this ethnic research is preference by both white and black children for white experimental stimuli."

In a review of the research that has occurred in the ten years since this review, Tyson (1985) quotes numerous additional studies that have found a white stimulus preference amongst *both* white and black children in the United States. This preference for white children is not merely typical of the situation in the United States but has been found in both white and black children in South Africa, white and Maori children in New Zealand, white and Indian children in Canada, white, West Indian and Asian children in Britain, white children in France and Italy, and amongst Japanese children. Such a preference has also been found among other minority groups in the United States, namely the Chicanos and the Chinese (Tyson, 1985). These and other findings have almost always been interpreted as indicative of embryonic prejudice in the white subjects and of self-rejection, psychic damage and low self-esteem in minority subjects. Tajfel (1981, p.12) unequivocally states that :

"There is a good deal of evidence that members of groups which have found themselves for centuries at the bottom of the social pyramid sometimes display the phenomenon of 'self-hate' or

self-depreciation. It was one of the merits of the studies on in-group devaluation in children to have provided an accumulation of clear and explicit data on the subject."

Several important studies, however, have contradicted the above findings. With a sample of seven and eight year old children in Texas (Gregor and McPherson, 1966) and four to eight year olds in Omaha Nebraska (Hraba and Grant, 1970) black children preferred black dolls significantly more than white dolls. Banks and Rompf (1973) following research on black and white children concluded that ' no consistent white preference in blacks was found to support an interpretation of global self-rejection'. Banks (1976) states that 20 per cent of the 21 studies he considered demonstrated black preference, 10 per cent demonstrated white preference, and 70 per cent showed no preference. Aboud and Skerry (1984) reviewed an additional 16 studies and brought the total up to date as follows : 27 per cent reported black own group preference, 16 per cent demonstrated white preference, and 57 per cent showed no consensus on preference. Thus the pattern of identification and preference among ethnic minority children is not as clear cut as was once assumed.

According to Hutnik (1991), since the late 1960's studies have failed to find any consistent white preference and/or misidentification. A number of arguments have been put forward to explain this discrepancy. Banks (1976), for example, states that the responses of black children should not be compared with those of whites but against chance. A re-analysis of the data showed that when frequencies of doll choices are assessed against chance, 70 per cent of the studies which had been earlier interpreted as demonstrating white preference could now be categorised as falling into the 'non-preference category', non-preference indicating 'no consistent preference' for whites among ethnic minority children. Other researchers have suggested that the discrepant results may be due to methodological artefacts such as the race of the experimenter (Porter 1971), or contaminating cues, such as gender (Katz and Zalk, 1974), or physiognomy of the stimulus material (Gitter and Satow, 1969), or even the greater familiarity that both black and white children have with white dolls (Tyson, 1985). Hutnik (1991) raises the question of the limitation of doll choice techniques used in many studies of ethnic identification and preference. The instruments *force* the individual to make

a choice between a bláck and a white doll. However it is unlikely that ethnic identification and even ethnic preference is a simple either/or matter (Hutnik, 1991). The one study (Morland and Hwang, 1981) in which children were allowed to respond that they looked like 'neither' doll, indicates that the response of 'neither' with regard to ethnic self-perception turned out to be highly important in relating to ethnic identity to its societal setting.

A popular explanation of the observation that ethnic minority children are no longer showing such a strong preference for the majority group is that the new trend is due to changes in the socio-political climate surrounding ethnic minority groups. The civil rights movement of the 1960's along with the Black Liberation Movement are often quoted as bringing a gradual but widespread re-evaluation of black attitudes. Proponents of this view (Davey and Mullin,1980; Milner, 1983) point out that this reversal is relatively recent and that the development of black consciousness has brought about an increase in self-esteem, which in turn leads to an own group preference.

What, then, is the research evidence regarding self-esteem and membership in an ethnic minority group? Do ethnic minority individuals suffer lower levels of self-esteem than their majority counterparts or have recent historical changes actually resulted in higher levels of self-esteem?

Self-esteem Studies

Although studies disagree on whether the personal self-esteem of blacks is equal to or greater than that of whites, the majority of studies do not report lower personal self-esteem among blacks.

Young and Bagley (1979) found that higher levels of self-esteem tend to be associated with more pro-black responses in British West Indian children. Gordon (1963) found blacks to have the highest self-esteem of five groups. Large sample studies by Hunt and Hardt (1969), Hunt and Hunt (1975), Powell and Fuller (1973) all showed blacks with higher self-esteem. However, several studies do not support the improved self-esteem hypothesis. Branch and Newcombe (1980) found that children of black activist parents made more white doll preferences than children of less activist parents - a finding contrary to the improved self-esteem hypothesis and in line with the

damaged self-esteem hypothesis. Among blacks personal self-esteem varies with sex and region, but, again, the findings are not consistent. Several studies of children find that black males have lower self-esteem than black females (Baughman and Dahlstrom, 1968; Greenberg, 1972); others either report the opposite finding (Brand et al., 1974), or no difference between the sexes (Trowbridge, 1972). Some studies find higher personal self-esteem among northern than southern blacks (Crain and Weissman, 1972); other evidence shows higher self-esteem among southern blacks (Baughman and Dahlstrom, 1968). According to Porter and Washington (1983), differences in sample age and in methodology explain some of these discrepancies. Social class and degree of interracial contact also cause variations in personal self-esteem. A number of investigators have found that social class is a more powerful predictor of personal self-esteem than is race (Gordon, 1969; Yancey et al., 1972; Samuels, 1973).

Dreidger (1976) studied ethnic affirmation and ethnic denial and found little evidence of self-hatred among seven different ethnic groups in Canada. However, as predicted those who identify strongly with the ethnic group also show the highest ethnic affirmation, while those who are attempting assimilation show the least affiliation to their own ethnic group's behaviours and norms. Crocker et al. (1987) tested the experimental hypothesis of Wills (1981), that people low in self-esteem should engage in self-enhancement strategies by derogating the out-group, a hypothesis known as the downward comparison theory. Crocker et al. (1987) found that people who are low in self-esteem

(a) showed the same degree of favouritism towards the in-group over the out-group as did people with high self-esteem and;

(b) tended to rate both the in-group *and* the out-group generally more negatively than people who were high in self-esteem.

This is contrary to Wills (1981) theory. Crocker and Luhtanen (1990) then suggested that there are two types of self-esteem, personal self-esteem and collective self-esteem. Collective self-esteem was operationalized as the extent to which individuals generally evaluate their social groups

positively. They hypothesised that people who are high in collective self-esteem respond to threats to collective self-esteem by derogating out-groups and enhancing the in-group. Their study measured both collective and personal self-esteem and found that subjects high in collective self-esteem used an in-group enhancing strategy when their collective self-esteem was threatened, whereas subjects low in collective self-esteem did not. Analysis based on personal self-esteem did not show this interaction. Thus, according to Crocker and Luhtanen (1990), the predictions of social identity theory which suggest that people strive to maintain a positive social identity through in-group favouritism may apply only to people high in collective self-esteem, and not to those low in collective self-esteem.

Few studies of the self-esteem of ethnic minorities have been carried out outside the United States. The research findings of studies examining self-esteem in ethnic minority children in Britain are inconsistent. Studies by Bagley and Verma (1979), Lomax (1977), and Milner (1973) suggest that ethnic minority children in Britain experience problems in levels of self-esteem. Contrary to these findings, Stone (1981), and Bagley, Verma and Mallik (1982) indicate that ethnic minority children in Britain do not have lower self-esteem in comparison with their indigenous counterparts. A principal finding of Khalid's study was that the Pakistani children's level of self-esteem was comparable with the majority children. Khalid states that Pakistani children's significant others whose judgement they value and trust were more likely to be members of their own ethnic community (Khalid, 1983). For Khalid, based on her own previous studies (1983; 1985), a vast majority of Pakistani children compare themselves with other Asian children, particularly the children they interact with. Therefore, in light of the reflected appraisal principle, Pakistani children are likely to see themselves through the eyes of their own community's children (Khalid, 1988). Rosenberg (1972) found a similar phenomenon regarding self-esteem of blacks in America.

Thus, most studies of black self-esteem using well established scales indicate that there is no difference in self-esteem between blacks and whites (Gaskell and Smith, 1981; Porter and Washington, 1979; Rosenberg, 1965; Williams-Burns, 1980). Wylie (1978) reviewed 53 publications dealing with the relationship between racial or ethnic status and global or specific self-

esteem. Viewing all these studies together, she concluded that there is little research evidence for those who have contended that the derogated, disadvantaged social position of blacks in the United States has resulted in a seriously damaged self-esteem.

These findings, which fly in the face of social psychological theory, previous experimental evidence and, some would argue, common sense, require some analysis and comment.

Rosenberg (1979), in an enquiry into the assumptions underlying self-esteem and minority status, states that most theoretical formulations assuming a relationship between the two rest largely on two concepts we have commented on earlier: reflected appraisals and social comparisons. As has been stated, reflected appraisals assumes that the self-concept is largely built up by adopting the attitude of others towards the self, it follows, therefore, that if others look down on the minority group, it will see itself more or less as they do. While accepting this in principle, Rosenberg (1979) points out that the conversion of society's attitude towards one's group into the individual's attitude towards the self is possible only if certain assumptions are made. These are; (i) that the individual knows how the majority feels about his/her group (the assumption of awareness); (ii) s/he accepts the societal view of the group (the assumption of agreement); (iii) s/he accepts these views as being applicable to her/himself (the assumption of personal relevance); (iv) s/he is concerned with majority attitudes (the assumption of significance). For Rosenberg, when all these conditions are met, then self-esteem will indeed be low. The fact that self-esteem is not always or even often low in minority individuals indicates that one or more of these criteria have not been met.

The principle of social comparison used by Tajfel (1982) holds that minority group members have lower self-esteem because they compare unfavourably with the majority group in a number of ways such as low social class position and poor academic performance. Again, accepting the principle of social comparison as fundamentally sound, for Rosenberg (1979) the fact that there is no evidence of damaged self-esteem among minority group individuals is possibly the result of blacks not using whites as their comparison group. Rosenberg (1979) believes that black children compare themselves with other blacks *not* with whites, doing so on the basis of the environment in which

they live. Thus, there is no reason to suppose that their self-esteem should be any different from that of whites. Hutnik (1991) takes issue with Rosenberg on this point and believes his argument is not a convincing one. Citing studies by Hoffman et al.. (1982) and Mann (1963), Hutnik states that studies of social comparison processes suggest that the outcome of deleterious comparison does not always result in damaged self-esteem particularly if other dimensions exist or can be created whereby a sense of psychological distinctiveness may be achieved or maintained within the minority. Hutnik agrées with Rosenberg that social comparisons during childhood may be made exclusively with members of one's own racial/ethnic group but believes that social comparisons with the privileged majority are inescapable in adolescence and adulthood, when occupational choices must be made, political ideologies formed and sex roles sorted out. However, for Hutnik, the fact that the minority group is also a significant comparison group, as Rosenberg argues, must be seriously considered. For Hutnik (1991), it becomes increasingly obvious that it is the *balance* of the individual's identification with *both* the majority group *and* the minority group that must be measured, in order to understand the different ways of coping with ethnic minority identity.

The above studies and discussion of their findings would appear to indicate that the assumption that ethnic identity is *the decisive* criterion in the self-concept of ethnic groups is untenable. Indeed, in reference to Hutnik's point regarding the importance of ethnic identity in adolescence, studies indicate that in comparison with body image and various dispositions, the importance of the evaluation of ethnic identity for global self-esteem was clearly smaller (Verkuyten, 1990 ; Rosenberg,1979). Hines and Berg-Cross (1979), on the basis of their work among ethnic minority adolescents come to a similar conclusion and state, *"Evaluation of one's self along racial lines is a contributing component rather than sole determinant of global self-esteem"* (p.272). A point of caution should be made here; these conclusions do not mean that belonging to an ethnic minority group is not important when considering self-concept and self-esteem. As Verkuyten (1990) states, it is possible for ethnic identity to gain primary significance in specific situations. For instance, the results of a study by Verkuyten et al.. (1984) found that adolescents from ethnic minorities who had left high school and could not find a job considered ethnic identity more important to their self-concept. This highlights the importance of variation within any ethnic group, even among members

of a single family. It also indicates that at an individual level, ethnic identity can change over an individual's lifetime as well as in response to different situational contexts, a factor that led Keefe to comment, *"this dimension of ethnicity is affected by a complex interrelationship of social, psychological , and cultural factors"* (Keefe, 1992:43).

As Verkuyten (1990) points out, self-concept does not have to correspond to a person's evaluation of the group's characteristics and, from a psychological point of view, not all components of the self-concept are equally important to a person, a fact often lost sight of. In most studies of ethnic self-concept and self-esteem, there is a short list of characteristic features for which a person has to rate his degree of agreement or disagreement; the question of their relevance to the individual is left aside. Rosenberg (1979) has pointed out, however, that this question is of crucial importance. A person may well see himself as non-athletic, but whether this has negative effects on his global self-esteem depends of course on whether he/she thinks it is important to be good at sports. The importance of the components to the correspondent must be taken into account in determining whether ethnic identity or other components of the self-concept have a dominant influence on self-esteem. This highlights the importance of a much wider perspective being adopted when considering ethnic minority self-concept and self-esteem. For Verkuyten (1990), the interrelationship of various factors must be determined in order to get a more complete and accurate idea of the problems of ethnic minorities and certainly of those problems that concern their self-concept and self-esteem, thus emphasising the importance of consideration of context.

This section of the chapter challenges the often unquestioned acceptance of theories that have been put forward to suggest that the psychology of minority group individuals has in some way invoked the concept of self-hate and low self-esteem. The lack of a relationship between self-esteem and membership of an 'inferior' group cautions against assuming a one-to-one relationship between ethnic identity and self-esteem. The little evidence that exists of minority group individuals who lack pride in their group, indicates that even 'group self-hatred' is not a common phenomenon among minority groups. That is not to say that being a member of an ethnic minority group does

not result in situations where one's ethnicity is not a factor (e.g. when it is abused) influencing self-concept and self-esteem. Nor is it to say that the role of ethnic identity in self-esteem, its relationship to acculturation, and its place in personal identity does not merit further research. I believe, for example, that the individual's evaluation of and emotional contentment/emotional pressures of belonging to an ethnic minority group are worthy of investigation.

Currently, however, researchers can offer few clear answers to the questions of consequences of belonging to an ethnic minority group and its effect on self-concept and self-esteem because of widely differing approaches to the study of ethnic identity including lack of agreement on what constitutes its essential components, varying theoretical orientations that have guided the research, methodological problems of the research, and the measures that are unique to each group. The task of understanding ethnic identity and its effect on self-esteem is complicated because the uniqueness that distinguishes each group makes it difficult to draw general conclusions. One example of this is the way in which the term 'black' is often used in a blanket manner when researching or describing ethnic minorities when in fact covering a plethora of heterogeneous groups.

Conclusion

What can be concluded from this literature review with respect to the mental health of the South Asian community in Britain? What is clear is there is a need for hard epidemiological data about the rates of disorder given the lack of and/or the weaknesses of studies in this area. Despite this, it is apparent that most of the common disorders such as depression, anxiety disorders, eating disorders and experiences of emotional distress linked with parsasuicide, are present in Britain's South Asian community, particularly second generation South Asian women. There may be cultural factors in the recognition and presentation of mental disorders in this community but this appears to be mainly with first generation South Asians.

This chapter identified the importance of self-esteem to a person's mental well-being. On the basis of studies on self-esteem, it appears that having low self-esteem, i.e., not having a favourable

recognition and evaluation of oneself, increases the chances of that person becoming depressed. Self-esteem studies suggest that whether or not a person meets their aspirations, goals and ambitions impacts on their self-esteem and, therefore, on their mental well-being. The recognition of this is important for this thesis. In later chapters, it will become apparent that failure to achieve individual aspirations and goals is an important factor in the development of depression in women generally, and with respect to the women who participated in this study, in the development of depression in second generation South Asian women also.

What of the issue of ethnic minority self-esteem? This is clearly a contentious issue with some very strongly held opinions on all sides. I take the view that racial discrimination is a phenomenon likely to be experienced by a majority of the South Asian community in Britain and is a factor which should be seriously considered when assessing possible factors impacting on the mental health of South Asians in Britain. Can we say, however, that this factor in and of itself leads to depression or that every South Asian who experiences racism will become mentally ill? It is my view that whilst discrimination, disadvantage and exclusion can be and often are significant components of ethnic minority experience, we can often forget or ignore the fact that human behaviour is not solely determined by forces that constrain, and ethnic minorities, in this case South Asians, have the capacity to resist exclusion and discrimination. Consequently, the suggestion that ethnic minorities will automatically have lower self-esteem
(and thus be more at risk of depression) because of racial discrimination is an assertion yet to be consistently demonstrated and one that, at best, remains very much open to question. Clearly other factors must also be considered if we are to avoid simplistic, single factor explanations.

Based on evidence from available studies of second generation South Asian women, as with white indigenous women, the most common mental health problem is depression. On the basis of the studies reviewed in this chapter it seems that isolation, discrimination, poverty, intergenerational conflicts, culture conflict and lack of satisfaction with, and conflicts over, women's expected roles, play a part in the onset of depression in second generation South Asian women. It has also been found that in recent years eating disorders, previously only associated with white 'western'

women, have been uncovered in second generation South Asian women and inter-generational conflicts and/or conflicts over behaviour and values have been identified as significant factors in the development of such disorders. This development and the findings linked with research on eating disorders is significant for this thesis. This is because these findings signify the development of a range of attitudes among South Asian women previously only thought to be associated with white populations. This represents, in my view, evidence of second generation South Asian women, as a consequence of socialisation experiences in Britain, acquiring certain attitudes and beliefs similar to those found in white indigenous women. The significance of such behaviour becomes apparent in later chapters.

The studies on depression among South Asian women outlined in this chapter demonstrate that a range of social factors are involved in the onset of depression in second generation South Asian women. These social experiences, and some of their consequences, will be addressed in Chapter 2 .

Chapter 2: Ethnic Minority Adaptation Processes and the Experience of Second Generation South Asian Women Abroad.

Introduction

This chapter will examine theories of the adaptation which have been used to analyse the experiences of ethnic minority migrants on arrival in their country of migration. Specifically, I shall look at the experiences of first-generation South Asian migrants and those of their children born and/or raised from an early age in the country of migration. In doing so, I shall assess the impact of these processes on second-generation South Asian women (i.e., those women born in South Asian countries or who arrived here aged 5 years or under). I will assess the impact of these processes in the context of their potential impact on the mental health of second-generation South Asian women. The purpose of this chapter is, then, (i) to analyse the theoretical issues relating to ethnic minority adaptation processes; (ii) to highlight the fact that adaptation processes within specific ethnic minority groups are varied and can on occasion lead to internal conflicts within such communities, in this case South Asian communities in Britain and other western countries; (iii) to show the divergent views of second-generation South Asian women in Scotland on how the acculturation process has impacted on their views and outlook with regard to women's roles, identity and marriage; and (iv) to demonstrate that for some second-generation women, adapting or attempting to adapt in a manner they believe most suited to themselves can be a stressful process which, as will become apparent in later chapters, can increase the risk of such processes having a detrimental effect on their mental health.

Ethnic Minority Adaptation Processes

The impact of migration, both on those migrating and on the receiving country, has been widely researched and a number of theories have been developed. Three main theories are addressed here: assimilation, pluralism and acculturation. This is not to imply that these are the only three, rather that they are the three most consistently addressed in the writings and research regarding ethnic minority adaptation processes.

Assimilation

Assimilation is characterised as a comprehensive process of modification in which migrant groups acquire the traits of the dominant society (Gordon, 1964; 1975). Gordon focused on ethnic minorities whose identities were formed in countries other than their current ones. Assimilation theory contends

that on arriving in a new country, immigrants undergo some degree of change and that as time passes, proportionately more immigrants and their descendants will accept the host society's way of life and closely associate with the dominant group on a primary group level. As immigrants and their descendants become more attuned to the host society's way of life, assimilation theory suggests that immigrants gradually discard their own ethnic social and cultural ties in favour of those of the majority.

Assimilation theories have been criticised for assuming that the host society would be welcoming and not discriminatory, thus facilitating assimilation into that society (Glazer, 1993). In posing the question "is assimilation dead?", Glazer considers the decline in the positive attitude towards assimilation as an ideal for immigrant and minority groups in the USA. Glazer notes that indigenous black communities were often totally ignored in assimilation discussions and concludes that the failure of assimilation to work its effects on blacks, as on immigrants, is a consequence of prejudice which has been responsible for throwing the entire assimilatory ideal into disrepute. For White (1993), the emphasis of assimilation theorists on culture means that economic relationships, which could affect the relationship between indigenous majorities and newly arrived minorities, have been downplayed, if not altogether ignored.

Assimilation theories have also been criticised for being ethnocentric in nature and for not taking into account the heterogeneity of the receiving society, implying that the reception immigrants receive will be the same regardless of the class and regional differences in the receiving society. Khan (1982) states that assimilation theory is deficient in that immigrants and their children may not necessarily wish to abandon their cultural and social traditions and assimilation theory underplays the fact that colour and race were and are significant and complicating factors which could prevent or delay assimilation, if indeed it were desired (Khan, 1982).

Heisler (1992) notes that whilst Gordon's model was an improvement on original assimilatory concepts, it suffers from a key limitation of assimilation theory: namely that attention is primarily on the new immigrants and their ability to adjust and be accepted by the host society, whilst the host

society remains practically unaffected and unchanged in this process. Heisler also highlights the absence of power relations and conflict in assimilation theories; consequently, conflict and change are seen as temporary interruptions in the "normal, ordered state of the uniform nation state".

The deficiencies in the assimilationist model, particularly its often simplistic assertion that change to indigenous majority cultures and lifestyle is an inevitable process, means its use is limited if one is seeking to understand the complexities of adaptation and change in ethnic minority populations. Consequently, it is of little value in helping to understand the range and diversity of experiences within South Asian communities overseas, particularly in this country.

Pluralism

In contrast to assimilation theory, pluralism contends that, regardless of length of residence in the host country, immigrants and their descendants retain social and cultural ties even against the encroachment of the influence of the dominant group, while they remain as an intregal part of the political and economic system of the host society. Highman (1980) notes that historically religious minorities in the USA (e.g. Jews) took this pluralistic position as a means to resist the encroachment of the Protestant influences and maintain their own separate identity . Kim and Hurh (1993) also note that the political and cultural ascendancy of the assimilation ideology stimulated the development of pluralism as an attempt to protect the lifestyle and social networks of immigrants and other minorities.

This theory has attracted criticism for suggesting that immigrant communities live in a placid, non-confrontational environment, and for not taking into account diverse forces on ethnic minority groups that can potentially induce conflict and change. In this vein, Bacal (1991) contends that the pluralistic approach to society corresponds to the liberal notion of the existence in society of a plurality of competing interest groups which eventually reach a level of equilibrium. Smith (1978) states, if pluralism is suggesting that inequalities in society can be eliminated by the application of the principle of equality of opportunity then it is not only useless but also a harmful fiction. For Bacal

(1991) the problem with the pluralistic approach is that it disregards the role of class relations and exploitation, which lie in the background of and/or closely relate to ethnically segmented societies.

Both Bacal and Smith state that although an attractive ideal, the notion that competing forces, both inside and outside minority communities, balance themselves out until a happy medium is reached is a false one. This is especially the case with ethnic minority communities who can often experience racial discrimination and disadvantage on a number of economic and social fronts.

Acculturation

The theory of acculturation suggests that ethnic minorities undergo a partial adaptation process in which they take up some of the values, customs and practices of the host society whilst also maintaining their own cultural and traditional norms. Acculturation has been defined as a group level phenomenon involving, for example, the dynamics of "selective adoption of value systems" and the process of integration with and differentiation from the majority culture (Berry, 1980). In psychology, acculturation research has focused on individual differences or within-group heterogeneity (Olmedo,1979). Berry (1974), a psychologist who extended the theory of acculturation to psychology, developed a model proposing that acculturative influences include such extracultural factors as western education, wage employment, urbanisation, settlement patterns, population densities, changes in socialisation practices, and the pressures to change under the impact of these experiences. The traditional culture, according to this model, is additionally influenced by the behaviour of growing individuals and their growing interaction with the environment. Berry's theory of acculturation, therefore, emphasises a multidimensional interacting system which includes the individual (Sodowsky et al , 1991).

The first question from Berry's acculturation model "*Is it valuable to maintain cultural identity and characteristics ?* " looks at the degree to which the person wishes to remain culturally at one with their indigenous background, in terms of identity, language, and way of life, as opposed to giving everything up to become part of the host society. The second question *"Is it valuable to maintain relationships with other groups?*" concerns the extent to which an ethnic minority individual wishes

to have day to day interactions with other groups, as against relating entirely to those in their own group (Berry et al, 1986). Depending on the answers to these two questions, Berry et al assert that there are four possible outcomes of the acculturation process; Integration, Assimilation, Separation, Marginalisation. A desire to maintain the person's own culture and engage in daily interaction with other groups with possible influences on outlook and attitudes characterises Integrationists. Assimilationists comprise individuals who adopt the dominant group's attitudes and behaviours whilst abandoning traditional culture and identity. Separationists wish to retain their own cultural traditions unchanged and avoid contact with the host culture. While separation is self-imposed, the minority group is also excluded by the dominant group. Marginalists have no desire to maintain their own ethnic or adopt the host's culture (Berry et al, 1986).

For Berry and Krishnan, one key factor determining the level of acculturative stress involves the immigrant's desire (a) to maintain one's own cultural identity, and (b) to have relationships with the host culture. This goes back to Berry's acculturation model to assess the impact of the answers to these two questions : "*Is it valuable to maintain cultural identity and characteristics*?" and "*Is it valuable to maintain relationships with other groups?*". Berry et al report that generally positive and negative answers to each of these two questions yield four acculturation strategies. These are (a) Integration (yes to both questions); (b) Assimilation (no to question 1 and yes to question 2); (c) Separation (yes to question 1 and no to question 2); and (d) Marginalisation (no to both questions).

There are a growing number of researchers who believe that acculturation is a "bidirectional" adjustment process (Berry, 1980; Mendoza & Martinez, 1981; Sanchez and Atkinson, 1983). According to these authors, acculturation of a minority person can be assessed on the basis of the degree of assimilation to the majority culture and the degree of retention of the minority culture. Mendoza (1984) has stated that individuals adopt different options of acculturation in different situations. A person might adopt (i) rejection in terms of marriage partner preference and religion, (ii) assimilation in terms of dress customs, and (iii) integration in terms of food and celebration of major holidays (Mendoza, 1984; Sodowsky and Carey, 1987; 1988). This approach, therefore, contends that the acculturation of a minority individual is best described by a composite profile rather than by a

single score. A number of researchers have noted that acculturation options differ among people of a minority group, probably depending on such sociocultural variables as ethnicity, religion, resident status in the country, sex, age, generational status in the country, years of residence in the country, occupation, education, income, age at entry into the country, geographic location, ethnic density of neighbourhood, rural versus urban residence, family structure and family size (Mercer, 1976; Garcia & Lega, 1979; Sodowsky & Carey, 1988).

The acculturation model offers the best opportunity of appreciating and understanding the complexities of adaptation with regard to the South Asian community abroad, as it not only allows for diversity within immigrant and ethnic minority adaptation processes but also because it recognises the adaptation process as potentially stressful and allows for the assessment of such stress on ethnic minority communities both collectively and individually. Important in my study of depression in second-generation South Asian women in Scotland is to what extent the acculturative process is, in and of itself, a stressful experience potentially implicated in depression. In assessing this it is first important to establish in what way, if any, the acculturation process is stressful.

Acculturative Stress

For Berry and Kim (1980), the difficulties that migrants face in new countries are numerous and include social dislocation and often significant cultural and psychological pressures to change. The concept of acculturative stress refers to stresses which are identified as having their source in the process of acculturation. In addition there is often a particular set of stress behaviours which occur during acculturation, such as lowered mental health status, specifically depression and anxiety. Berry and Kim (1980) noted that mental health problems do often arise during acculturation but that these problems are not inevitable. They do not claim that all immigrants will experience acculturative stress, rather that this will depend on a number of factors such as the nature of the receiving society, the type of acculturating group, methods of acculturation, social and psychological characteristics of the individual. All these will moderate between the acculturation experience and the resulting stresses associated with acculturation (Berry & Krishnan, 1992).

Following their study on acculturative stress in Mexican American women, Salgado and Nelly (1987) state that among the more ethnically loyal respondents the immigration experience is perceived as creating tension in their lives. This tension, they argue, is caused by strong ties to their own country and ethnic culture as contrasted with their wish to remain in USA in order to prosper economically. Such a dilemma created conflict for these women. Salgado and Nelly (1987) argued that "culture conflict" occurred when individuals attempt to accommodate to the values of the host society as well as trying to preserve their own Mexican culture. They recount that a number of women in their sample did not feel completely Mexican and reported an increased sense of being American.

Berry and Kinshar (1992) note that those with Integration attitudes, as opposed to other acculturative attitudes, feel relatively more at ease in both cultures and thus feel less overall stress. Following their study on acculturative stress among Indian migrants to the United States, they also found that Separation attitudes predicted psychosomatic stress symptoms and Assimilation attitudes predicated psychological stress symptoms. They in turn speculate that those who attempt to assimilate adopt western values of internalising stress and therefore show mental stress symptoms. On the other hand, those who express Separation attitudes still feel closely tied to the Indian culture where it is acceptable to vocalise and externalise stress symptoms via physical complaints i.e., in the manner they would have done in their country of origin. Although contradictory, what the above findings on acculturative stress suggest is that the migration process can involve a significant set of life events which, under certain conditions, can have adverse effects on the mental health of acculturating individuals.

Acculturation and Mental Health

A number of studies on mental health problems in migrants have reported higher levels of depression and other psychological disorders in comparison to the indigenous population. Other studies have contradicted such findings (Halldin, 1985). According to Berry and Sands (1993), these contradictory findings may validate Berry's assertion that the acculturative process does not automatically lead to acculturative stresses and mental ill-health, but that such outcomes depend on

characteristics of the dominant society and the circumstances surrounding the individual demonstrating a particular aspect of the acculturating process.

In a study on depression in first and second-generation Greek-Canadians, Berry and Sands (1993) found that the second generation experienced more stressful life events than the first-generation and that these correlated with marginality and depression in both generations. They also found that strong stable social supports, especially at times of stress, reduced or prevented the onset of depression. In relation to social support, Berry and Sands reported that strong friendships in the second-generation buffered the experience of marginality or general isolation and alienation. "*That is, having a peer to confide in and depend on in difficult times may bind a person to others, to their culture, and/or to the society in which the person lives*" (Berry and Sands, 1993).

Berry and Krishnan (1992) note that there are a number of moderating factors between acculturation, stress, and the development of mental health problems. Such factors include; (a) reasons for migrating - those voluntarily migrating appear to suffer less than those forced to leave their country of origin, (b) nature of the receiving society - a society more discriminating to migrants will mean more stress, (c) demographic background - migrants with similar language, socio-cultural and educational backgrounds are less likely to suffer acculturative stress. Alternatively, migrants from very different backgrounds in terms of language, socio-cultural, educational and everyday lifestyle could potentially suffer more acculturative stress. By raising the question of lifestyle and demographic background and their influence on the acculturation process, it is my assertion that these are critical factors in understanding the acculturation process when related to the South Asian community in Britain. Acculturation research has indicated that a number of factors influence interaction and the resulting outcome of such interaction involving indigenous majorities and ethnic minorities. Generational status, social class, country of birth, family structures and religion are believed to play a part in shaping the outcome of contact between ethnic minorities and indigenous majorities.

By addressing the factors of generational status, country of birth, family structures and religion, in this study I appraise the idea that among second-generation South Asian women, acculturation can be a stressful process due to the different socialisation experiences which help to shape the views and outlook of two generations of South Asians: the parents, who were born and raised in the Indian sub-continent and the children, born in another country with contrasting, often alien, values and traditions to those of their parents and in an environment that can be hostile to ethnic minorities. Although both generations live in the same country their experiences and outlook can be, and often are, quite different.

The South Asian Community in Britain

In the 1970s a number of publications were produced which claimed to highlight problems faced by youth of South Asian origin born in Britain (the second-generation) who had difficulties coping with the alternate demands of 'British' and 'Asian' culture. These included "Between Two Cultures" a Commission for Racial Equality publication, and Taylor's "The Half-Way Generation". Following this and other research, the term 'culture conflict' became synonymous with problems affecting second-generation South Asians in Britain. Research on suicide among young Asian women in Birmingham, for example, spoke of 'cultural conflict' as a significant contributory factor (Merrill, 1989; 1990). The different socialisation experiences, particularly in childhood and adolescence, of second-generation South Asians, were believed to be one of the reasons influencing these 'conflicts'. Intergenerational conflict is a common occurrence in many families and communities across a range of majority and ethnic minority communities. Why do such intergenerational conflicts occur in ethnic minority communities, specifically the South Asian community in Britain, and why, as I shall attempt to show, in some cases do they assume a special importance? A significant part of the answer can be found by looking at the socialisation experiences of first and second-generation South Asians and the impact on their lifestyles and outlook.

Arrival in a New Country: The Experiences of First-generation South Asian Migrants

First-generation South Asian migrants originated from societies characterised by interdependence, strong kinship ties and great respect for the authority of the family. In a British context, the receiving society represented something of a contrast, with more emphasis on the individual, and greater socio-economic independence.

Cochrane and Stopes-Roe considered the situation that first-generation migrants faced when they arrived in Britain and recounted the views of one such migrant. In the 1970s Dahya, recounting the immediate impressions of the new society he found himself in, stated that the immigrant "*has nothing but contempt for the British way of life.....which he regards as characterised by a decadent morality*" (Dahya, 1973: 264; from Cochrane & Stopes-Roe, 1990). Ten years later a similar message was being recorded. According to Cropley (1983), South Asians still found British ways "*immoral and heartless.....marriage is frequently marked by infidelity and divorce is common. Parents do not supervise their children properly and fail to teach them the right way to behave. Children do not respect and obey their parents and neglect them wickedly when they grow old*" (Cropley, 1983: 96; cited in Cochrane and Stopes-Roe, 1990).

The immigration process therefore introduces new factors into the situation and when ethnic minorities feel threatened by a hostile majority, they make efforts to preserve their identity often by vigorously emphasising social and cultural traditions (Cerroni-Long, 1984). Studies both in this country and abroad have drawn attention to some of the complexities involved when minority groups settle in an environment which can be both alien and unwelcoming. Thus, as Cochrane and Stopes-Roe (1988) note, some members of ethnic minority groups may be more traditional than those back home, not in the position of being threatened by an alien society, would feel the need to be. Commenting on this phenomenon, Gordon (1986) notes that "*one method by which South Asians have protected themselves against abuse has been through social and geographical clustering*" (Gordon, 1986). ....."*This has had a significant impact on the scale of South Asian communities found in Britain today*" (Clarke et al, 1990:23). This theme is continued by Peach et al (1988)- "*Asians still remain tightly residentially clustered in cities such as Bradford, Leicester and*

Blackburn.....clustering not only serves a defensive function against racial harassment, but also provides a market for community services.....It also allows the re-creation of dense traditional social networks with all the implications this has for quality of life and transmission of culture" (Peach et al, 1988:592).

In this context, Taijfel (1978) suggests that the more sharply specified and unchangeable the boundaries between two groups are perceived to be by group members, the less the chance that they themselves will engage in personal behaviour which would cross these group boundaries. Moreover, groups which are disadvantaged in various ways may emphasise customs and traditions which enable them to maintain a distinct social identity. In the same vein, Wakil (1981), noted that following their arrival and settlement in Canada, first-generation Indian migrants received an unfriendly response and became extremely conscious of their minority status which reinforced their insecurity in a white society. The result of this process, states Wakil (1981), was a "*strong anti-assimilationist attitude*" accompanied by accordant and intentional efforts to resist the external pressures to change. Consequently, many first-generation migrants were convinced that without a strong, cohesive and stable social structure that would assist in the preservation of their identity, values and social customs, their survival would be in jeopardy. A similar discriminatory response met South Asian migrants on their arrival in Britain (Rex and Tomlison, 1979), and these factors combined to augment the belief among South Asian migrants in the superiority of the traditional family organisation and in the necessity of holding on to it, if not in its original form, then in its close approximation. Anything that threatens this is likely to result in internal tensions and disputes. To what extent was this possible in a new and very different social environment?

Early migrants to Britain from the Indian subcontinent were mainly from peasant families with restricted land holdings. In these circumstances a son or sons would go abroad to develop the family's income. Although the initial idea was to stay for only a certain period of time, as they became more settled and established in Britain, consideration was given to bringing over wife and family (Ballard, 1982). These misgivings about British society and its potential effects on their families meant that a majority of South Asian migrants made enormous efforts to sustain the unity

and traditions of their families as this was perceived as a powerful barrier against the negative influences of British culture. Commenting on settlement patterns among South Asians in Britain, Ballard (1990) notes "*Settlement in Britain has, of course, been strongly mediated by kinship.....everyone joined kinsmen and acquaintances who were already established overseas. Thus despite their location thousands of miles from home, most migrants continued to live and work alongside their kinsmen and fellow villagers*" (Ballard, 1990:234). Later Ballard (1990) notes, "*Varied and changing though their personal lifestyles may be, their preferences are still inspired at least as much by their roots in the subcontinent as by their more local, British, experience*" (Ballard, 1990:219). As a consequence of this and other factors mentioned, the family and kinship structures took on as much if not more importance for South Asians as in the different areas of the Indian subcontinent they migrated from. What, generally speaking, was their form?

Family and Kinship Structures: An Overview

As Ballard (1982) notes, it is possible to find every familial structural variation in the Indian subcontinent, but at the same time, it is possible to comment on such family structures in a generalised manner. As he later stated, "*The conventions of family and kinship organisation used by Hindus, Moslems and Sikhs are virtually identical* "(Ballard, 1992:230).

South Asian families as a social institution are characterised by structures which vary on the continuum of nuclear-joint, as well as matriarchal and, most commonly, patriarchal types. The South Asian family is typically three generational and subject to the authority of the eldest male. It consists of a man, his sons and grandsons, together with their wives and unmarried daughters. A man or woman must be conceptualised as existing in a complex network of rights and duties which extend from the central core of the immediate family to a wide set of paternal and maternal kin relations. Reputation or status is dependent on this network, and on the fulfilment of rights and duties inherent in a position at any particular time. It is assumed that obligation to the group would always be put before personal interest (Saifullah Khan 1976; Ballard 1982; Shaw 1988).

Following her research on a Pakistani community in Britain, Shaw (1988) noted that "*Pakistanis' idea of what a family is and what roles family members should play is also unlike that generally found in English households*" (Shaw, 1988;73). The individualism and independence so valued in the West appear selfish and irresponsible to the person living in this context. For Brah (1978)"*One of the most important features of the extended family is that the interest of the family takes precedence over the interest of the individual*" (Brah, 1978). Such a family is "*incompatible with both personal ambition and the increasing individualism of the age*" (Suda, 1978). These and other and others who conduct research involving South Asians have stated that this is the relationship which in principle traditionally holds in Sikh, Hindu and Muslim families (Cochrane and Stopes-Roe, 1990). Each family member is accorded a specific position according to her/his age, order of birth and gender. Men and women are not regarded as members of the same group - each have their own equal but different status, with their own characteristics and resources. Relationships between women are less formal than those between men, although there does exist a hierarchy of age and status. Shaw (1988), observed that the limitations placed on family members reduce the opportunity for individual inclinations and initiatives, for both women and men.

On the other hand, Ballard (1982) noted that the widespread accessibility of wage work open to first-generation migrants to Britain changed the balance of power within the family in that wives were no longer economically dependent on husbands, nor sons on their fathers. Housing also had its effects on the migrant families. Because of the lack of availability of large houses that were in good condition and reasonably priced, many migrants had little alternative but to move into smaller dwellings and therefore split the family into several domestic groups (Ballard 1982). This resulted in women being in charge of their own domestic establishments much sooner than they would have been had they not migrated. There was not necessarily complete dispersion of the family group, however. Many families living in the same city, street, in the same or adjacent neighbourhoods, regularly visited one another (Ballard 1982).

The need to earn an income from wage work, especially for working class immigrants, placed demands on family members of working age to enter the labour market irrespective of gender. The

dilemma became how to maximise wage contributions to the household while at the same time preserving gender roles and identity within the context of the family (Humphrey, 1990). This raised questions about the role of women in the family in the new context of the country of migration.

South Asian Women and the Family

The position of women in any patriarchal environment is critical in attempting to understand the dynamics of family relations, in this case especially relating to the impact on second-generation South Asian women living in Britain. Liddle and Joshi (1986) refer to patriarchy as a system of family organisation which includes the authority of the father over women and younger women supported by a cultural tradition which emphases the supremacy of male power. In such an environment, the patriarchal ideal (although women may not accept it unquestioningly) of Muslim, Hindu or Sikh women, according to Kishwar and Vanita (1984), is to be "humble, meek, hardworking, quiet, passive and non-competitive with men." In such an environment men and women are separated by the conventions of purdah. There are variations of the system of purdah relating to class, urban/rural background, and education which mirror the cultural, socio-economic and ideological diversity in the Indian subcontinent (Kishwar and Vanita, 1984).

For Saifullah Khan (1976), purdah is a system of social control that regulates relations between the sexes. It aims to preserve the moral standards of society by emphasising, thus reinforcing, accepted values. Purdah is a public performance on an established stage open to examination of a knowing audience. From the day a girl is born, both parents prepare their daughter to uphold the family's reputation by strictly adhering to the norms of society. Purdah ensures that women will taint neither the honour of a girl's natal family nor her affinal family (Saifullah Khan, 1976).

Generally , the appraisal of women is very much in the context of family honour, pride, loyalty, self-respect, reputation and modesty. This is known as *izzat* (Shaw, 1988). Should a woman challenge or bring into question her husband's or her father's honour publicly, this would bring shame on these men and damage their honour. In such a situation a woman can bring catastrophe on herself and her family through her actions. The ideas of honour and shame thus strengthen the formal hierarchy of

relationships within the family (Ballard, 1982). The traditional notions of the role of women are not, of course, unique to South Asian families. Western feminists have long since argued that the family, particularly the position of women in the family, is the locus of women's oppression in the West also.

Humphrey (1990) notes that following migration the cultural sensitivity of male-female relations becomes especially notable as social ties shrink around the nuclear household. Taken away from an environment in which degrees of social distance could be differentiated and regulated by kinship, marriage, family standing and membership of a religious community, gender is recast as a confrontation between the inside/outside, the familiar/foreign and the safe/dangerous in an alien social environment. In this context an emphasis on gender which celebrates modesty, privacy, dependence and obedience seeks to enclose women within a socially narrowed arena. They are made the object of male 'protection' and the vehicle through which the moral preservation of the family is secured or lost (Humphrey, 1990). Afshar (1989) notes that women can easily have *izzat*, but they can all too readily lose it. To uphold *izzat*, wives, sisters and daughters must be seen to behave with modesty, as defined by their own community's standards but when young South Asian women reach school age they are subject to other standards of behaviour which could be at odds with their own family's and community's values and standards. What are the consequences of this scenario?

Socialisation of Second-generation South Asians: Its Form and Consequences

A commonly accepted definition of socialisation comes from Brim (1966) who describes socialisation as the process by which individuals acquire the knowledge, skills, and dispositions that enable them to participate as more or less effective members of groups and the society (Brim, 1966). Socialisation of children goes through various stages from infancy, pre-teens and sex-role socialisation. The parents have a significant impact on the life of the child in infancy which continues with less intensity as the child gets older (Kurian, 1986). Once the critical faculties of children are sharpened by schooling and broader cultural exposure, the gap between them and their parents often widens. When people see themselves and others interacting with each other, these act as a guide to behaviour in everyday life. The consequences of this, however, may not be what is

expected according to South Asian parents. Brah (1978) suggests that intergenerational understanding within the South Asian community in Britain breaks down when the "*locus of early socialisation of the two generations is separated not only in time but also by countries with differing social and cultural differences*".

Addressing the issue of socialisation experiences among second-generation South Asian adolescents, Ghuman (1991), following a study of South Asian youngsters in the West Midlands of England, stated

> "*second-generation 'British Asian' adolescents are growing up in two distinctive cultural contexts - one of the home and the other of the school. The home represents the traditional values, beliefs and attitude orientations, whereas the school embodies the values and norms of British society* " (1991: 121)

Understanding such processes becomes clearer if we take into account the "ideal" goals of socialisation among South Asian children. There is a range of experiences found in the South Asian community with class, caste, and religion impacting on these experiences. For example, my interviews with Sikh women in Edinburgh and Glasgow highlighted some of the differences within the Sikh community. The Sikh interviews in Edinburgh took place in Leith where the women were Bhatra Sikhs, a section of the Sikh community which is thought to be more conservative than other Sikhs, whereas in Glasgow a less conservative trend is apparent. In Britain's Muslim community, despite the negative way their religion is often portrayed in the media (e.g., as Eaterman (1992) has pointed out, all Muslims are portrayed as fundamentalist, and intolerant of other religions), there are a range of interpretations with respect to interpretation and practice of Islam.

In the following section, I discuss the literature on identity in Muslim, Sikh and Hindu before moving on to data on this issue from my own study. I have included a brief overview of the literature on marriage patterns in the South Asian community in Britain as a prelude to quoting data from the women participating in my study. Ethnic intermarriage can be used as an index of acculturation and,

as I argue that the acculturation process is a critical aspect of the life experiences of second-generation South Asian women, this material provides a useful indicator of the acculturation process among second-generation South Asians generally and, specifically, its effects on the women participating in my study.

Identity Among Muslims

It is estimated that there are over one million Muslims in Britain, about two thirds of South Asian origin, and that this figure will grow in the future (Modood,1990). One interpretation of Islam is that as it is based on the eternal message of God. It follows that it cannot vary at any time, place or nationality. Change as such, therefore, becomes irrelevant (Ahlberg, 1990). This is the way Islam is often portrayed, particularly in the media: i.e. monolithic. However, as Edward Said points out

> *"It is very much the case today, that when dealing with the Islamic world, all one billion people in it with dozens of different societies, half a dozen major languages, all of them spread out over about a third of the globe, American or British academic intellectuals speak reductively, and in my view irresponsibly, of something called Islam'. They talk as if Islam was a simple object about which grand generalisations, spanning a millennium and a half of Muslim history, could be made and about which judgements concerning the compatibility between Islam and democracy, Islam and human rights, Islam and progress could quite unabashedly be advanced".*
>
> Said (1994: 23)

In an earlier text '*Covering Islam* ' Said notes

> *In madrasses, mosques, clubs, brotherhoods, guilds, parties, universities, movements, villages and urban centres all through the Islamic world surge still more varieties of Islam, many of them claiming to guide their members back to the 'true Islam'.*
>
> Said (1981:60)

Said's assertion regarding the divesrsity of the practice of Islam is demonstrated in the different ways in which Muslim women in my study described and discussed their own identity. In my data analysis section "Acculturation and Identity" it emerged that far from being a uniform or even a coherent movement, identity for Muslim women embodies a number of diverse actualities. This is important as it demonstrates that not everyone shares the same view of what being a Muslim means. However, for the purposes of this study, I will attempt to show that where Muslim ideals are applied in a more rigid, inflexible manner against the ideals and wishes of some second-generation women, role conflict is a distinct possibility. An example of this rigid applicability comes from Rashid (1988) who states:

> *"Socialisation for Muslims involves providing children with an understanding of their purpose in life (submission to Allah; 51:56, 2:21, 31:22) the goal of their life (return to Allah; 6:60) and a means of accomplishing the purpose and achieving the goal.....Socialisation in the Islamic context must be defined, therefore, as the process of maintaining the child's Muslim identity from infancy to adulthood. Socialisation is successful when a Muslim adult, both submissive to the will of Allah, and knowledgeable of why Allah's will must be submitted to, emerges from childhood. It is unsuccessful when something other than a Muslim identity is seen in the new emergent adult"*
>
> (Rashid, 1988:209).

Writing in the context of being brought up in America, but relevant in the case of Muslim children in the Britain, Rashid states *"A Muslim child cannot be raised in America without being confronted with the Western world view on a continuous and sustained basis. Every aspect of his or her Islamically oriented socialisation is undermined by various elements in Western culture."* (Rashid, 1988: 210).

Commenting on some of the consequences of such a situation, Hussain and Hussain at The Islamic Foundation (1982), following their research on families who migrated from Pakistan to England (Oldham) stated that :

> *Over the past few decades, Muslim families from the Subcontinent have migrated to Britain in large numbers and have raised second and third generation children. Their adjustments within the new cultural context of their Country of Migration has created many adjustment problems. Such problems have emanated primarily from the cultural and religious role differences brought from their country of origin into the Country of Migration. Role strain and role conflict have been the result of such inter-cultural interaction.* (Hussain and Hussain, 1982: 40)

They also noted:

> "*Furthermore, role strain and role conflict occurs due to the incompatibility of role performance and role expectation of the role partners and the greater the difference between them, the greater the strain or conflict; the lesser the difference between them the lesser the strain and conflict.*" (Hussain and Hussain, 1982:41).

The pressures which Hussain and Hussain refer to are only part of the competing voices influencing second-generation women.. Many young South Asian women are also pressurised and influenced by their white peers in western countries. In his book "*American Jihad: Islam after Malcom X* ", Steven Barboza gives an informative account of the experiences of Muslims in America, many of them in their own words. One instance comes from a young Indian Muslim woman living in San Jose, whose parents migrated from India

"I consider myself a Muslim vagabond. I find that I am not completely at home here in America. I used to look at myself as being a tennis ball going back and forth on court, trying to be like the perfect Muslim girl so to speak, or the American girl in my high school. There's strong pressures on either side trying to put you in a box."

Barboza (1994: 253)

Hindu and Sikh Identity

Research among second-generation Indian women who are Hindus and Sikhs, for example Ghuman (1991), Cochrane and Stopes-Roe (1990), Bhachu (1991), and Drury (1991), suggests not dissimilar processes are at work to those among the Hindu and Sikh women I interviewed. Following her study of Sikh girls and ethnic culture, Drury (1991), concluded:

"the main majority of my second-generation respondents did maintain many aspects of their ethnic culture especially within the boundaries of the Sikh community. However, it is important to note that whilst some were very happy to do so, others were less dedicated and only deferred to pressures from their families and other members of the Sikh community, thereby containing or avoiding open tensions "

(Drury, 1991:398).

When Drury (1991) states that some second-generation Sikh girls deferred to family and other pressures to maintain aspects of ethnic culture, it is reasonable to note that where they refuse to defer to pressure, tension and open conflicts could arise.

In relation to Indian (mainly Hindu) migrants abroad, returning to Wakil's (1981) study, points of contention between parents and their children born in Canada were most noticeable in the area of dating and marriage. Most of the parents were extremely reluctant to let their children go out socially, especially where it meant mixing with the opposite sex. Whilst some parents were willing to allow

their sons to date and associate with the opposite sex, they did not grant the same freedom to their daughters. Parents believed strongly in the superiority of the arranged marriage system and feared the growing desire of their children to associate with their white peers. The parents' fear was based on the opinion that this tendency might result in an increase in inter-ethnic marriages which, they believed, would result in their next generation disappearing or becoming difficult to distinguish. In Wakil's study, 57% of parents and 67% of young people thought an increasing number of young people would rebel against the arranged marriage system. Girls brought up in a Canadian environment believed that boys must be prepared to forego their traditional authoritarian attitudes and accept them as equal partners in marriage. He also found a greater awareness, or commitment, of first-generation migrants to the notion of family honour (*izzat*) when compared with Canadian-born second-generation Asians. The desire of the second-generation to retain their cultural values, for example, the respect for age and authority was less than that of their parents who expressed a strong desire.

In relation to Hindus and identity formation, from a slightly different source than normal, attention could be drawn to a recent British film *Bhaji on the Beach* directed by Ghurinder Chadha and featuring three generations of South Asian women who carry with them a complex range of problems associated with growing up in a western cultural environment. Domestic violence and Asian-black relationships are prominent themes. Speaking to a Scottish newspaper about her film Chadha stated-

> "*What I wanted to do was to look at how we combine our Britishness and our Indianness, and at the effect Britain had on our structures in terms of family and of women and how things had changed. We were at pains to show that not everything in Britain was brilliant, nor bad. The film comes from the dualism of the main character ..... what people find very hard to deal with is the idea that we can be both British and Asian. I am able to combine something new British-wise, but also Indian-wise* "(The Herald, 16/8/93).

Following the film's release *The Guardian* reported that some Hindu religious leaders warned parents of the "damaging effect" it might have on their daughters and said that Asian men would keep watch outside the cinema. The paper reported "'*Many of the girls rushed out straight after the screening and when we tried to take photographs for publicity purposes they turned their backs and said they had been threatened if they went to see the film', a community worker said.*" (Guardian, 14/3/94).

In the light of the above sources on identity it appears that conflicts can arise when South Asian cultural traditions clash with goals and socialisation experiences of second-generation South Asians living in the west. These conflicts tend to be especially prominent (although by no means exclusively) among second-generation women. The outcome of such conflicts varies.

Mirza (1992), draws on Das and Bardis, (1978), who note that one of the major goals in the socialisation process in South Asian women is to imbue the psychological feeling of dependence on the male and not to be self-reliant. For Mirza, there is a significant difference between this phenomenon as applied to parents who grew up in South Asia and many second-generation Muslim girls in Bradford (England) who, Mirza states, "*are not willing to accept this passive approach..*" (Mirza, 1992:19).

Following their study in relation to the maintenance of traditionalism among South Asian families in Britain, Cochrane and Stopes-Roe (1987) note that the effect of respondents' gender was significant. Fathers and mothers did not differ in their response but there was a significant difference between sons and daughters. Similarly, Ghuman's 1991 study of South Asian adolescents found that both boys and girls favoured the incorporation of British values except the changing of names and ignoring the language. Differences between boys and girls were most marked on items relating to the role of women and equal treatment of boys and girls and acceptance of marriage customs. Ghuman concluded that gender differences were the most consistent factor to emerge from his study and that this ran across religious and class variables. Northover (1989) found similar significant differences among Gujarati girls in the East Midlands. Ghuman believes that these differences are a consequence

of "*the position of women in Asian communities*" (Ghuman, 1991: 127). According to Ghuman, even the liberal-minded Hindu and Sikh parents often discriminate against girls and favour boys over such matters as choice of clothes, friends and leisure time activities and are even tolerant of their boys going out in the evenings (Ghuman, 1991). For Ghuman, this is a reflection of the pressures on women to uphold the honour of the family. One could speculate that some of the pressures on South Asian communities, particularly the very negative representations in Britain of Muslims and the Islamic faith, may have actually increased the pressures on women as sections of this community pull together in a protective manner. An example of this is the growing trend of community leaders calling for separate Islamic schools funded by the state in the manner of Roman Catholic and Jewish schools. One such advocate, Dr Azam Baig the principal of an Islamic school in London, gave a clear indication about the education and role of Muslim women in Britain in an interview in *The Independent on Sunday* (4/4/93):

> *"Some of the girls want to be scientists and doctors, and we are preparing them for that. But at the same time their most important duty is as Muslims, and they have responsibilities as mothers and wives. Personally, I think they have more to contribute in this way, because they are shaping a new generation. I think it's much more rewarding - and the rewards are not only in this life, they are in the hereafter."*

Such an opinion reflects a desire among some sections of the Muslim community, and within Hindu and Sikh communities, to maintain the traditional family bonds and the role of women within this. This, as I have shown, may be at odds with some second-generation women. For example, Cochrane and Stopes-Roe (1990) highlight that comments favouring individuality over family wishes were more likely to be made by South Asian daughters than sons. Daughters from South Asian families were less traditional in their attitudes to the family than were sons. They speculate that the source of this difference in traditionalism may lie in the increase in range of opportunities and possibilities currently opening up for women by comparison with those open to previous generations. Sixty per cent of daughters compared with 35% of sons believed the individual came first; 22% put the family first compared with 40% of sons. In their study, a very telling finding was that 94% of both mothers

and fathers, but only 57% of sons and daughters believed "*izzat*" was very important. Notably, they found that "*young people who discarded traditional family honour thus could come into conflict with parents, none of whom felt that it was other than important. In fact a third of family dyads were in this position, but over half of young people agreed with their parents about the importance of izzat, and the rest were prepared to respect it for the sake of others*" (Cochrane & Stopes-Roe, 1990: 76).

On the basis of their study, Cochrane and Stopes-Roe stated "*the Asian younger generation was certainly less traditional than the older in outlook, and on a direct quantitative assessment this might indicate the possibility of conflict*" (Cochrane & Stopes-Roe, 1990:77).

Following the violent confrontations in Bradford between police and South Asian youths in June 1995, Bhiku Parekh (a South Asian Professor in political theory) noted that over the past few years South Asians have felt deeply uneasy about the ease with which the wider culture has penetrated their own ranks. He went on to state in *The Independent* (12/6/95)

> *All this has naturally worried...the community. It undermines their traditional values, subverts their family life and heightens the inescapable inter-generational tensions within the community. The older generation fears losing its youth, and the dreams that drove it to Britain lie in ruins. Predictably, this has generated a climate of moral panic.*

For Ghaffarian (1987), the comparison between current possibilities and previous restrictions is what is important rather than present actualities of this situation. With the ideals of feminism and equality for women more widespread than ever, daughters in both Asian and British cultures often feel themselves to be disadvantaged and may see benefits in supporting a shift away from the traditionalism that governed the lives of their mothers. Cochrane and Stopes-Roe (1990) state that it seems that in more than half the South Asian families with daughters the parents themselves were aware that the traditional demands to which they were accustomed were not now applicable, and were prepared to allow their daughters more licence. This is an important point as it highlights that such 'licence' exists and varies from family to family.

Cochrane and Stopes-Roe (1990) note that young people of South Asian origin share many of the educational experiences of their British peers, experiences frequently different from those of their parents. Cochrane and Stopes-Roe believe they will be less disadvantaged than their parents in English language and other social and employment related skills, and will have shared more of the experiences and attitudes of the majority society than their parents. However, they will still be subjected, as is every child, to the influence of the culture and values of their parents and community. As Brah (1978) notes, early socialisation for pre-schoolers and primary school children takes place, particularly in South Asian families, within the immediate cultural group; thus it seems that, apart from exposure to TV, all young South Asians might be well socialised into the fundamentals of their own group's structures, roles and values. Although Brah does not say this one could suggest that these fundamentals may well be directly affected by acculturation already. In recognising this possibility, Cochrane and Stopes-Roe (1990) point out that since traditions and experiences are to some extent shared within families, the generations may share attitudes; but the change in life experiences of the young, particularly the South Asian youth now in Britain, compared with those of their parents at a comparable age, might involve inter-generational differences.

Where such possibilities actually happen, the consequences can bevery significant. Although not necessarily addressing the issues in an in-depth manner, the British TV programme "East" (Channel 4 16/2/94), entitled "Nowhere to Run" focused on such stark consequences and what it called *'the ever increasing problem of young women leaving their homes because of restrictions their families place on them'*. In the programme a South Asian woman with long experience of working as a family counsellor in the South Asian community in Bradford stated: " *A long term solution is a re-education for the community. We should not sweep these problems under the carpet. We should not any more not say what is going on.*".

Such television programmes, and the often sensationalist newspaper coverage, have resulted in the 'culture conflict' label once again being used whenever problems affecting second-generation South Asians, particularly women, are raised. The widespread use of the term 'culture conflict' has been criticised by those who warn against the dangers of negative stereotyping of the Asian family and its

traditions. For Littlewood and Lipsedge (1989), whilst 'parent-child differences' are called just that in white families, in Asian families, these difficulties are often perceived by statutory services as clashes over cultural values rather than individual personality differences or the dynamics of everyday life. Ahmed (1981), whilst recognising that family conflict can exist as a result of conflicts between traditional Asian and western values, points out that there are other forces outwith the Asian family that affect people's lives but that too often services working with the Asian community fall back on the 'culture conflict' label rather than having a more detailed analysis of the client's personal situation.

That conflict can arise, over the roles and behaviour of women is not in doubt. It would, however, be misleading to imply that such conflicts were universal and the inevitable result of socialisation of South Asian girls and women in Britain. Brah (1978) makes an important point when she says "*the continuing socialisation of adults is sometimes not sufficiently taken into account. In the context of inter-personal levels of power in the family....Asian youth has far greater control than is often assumed.*"

There is no doubt that a range of attitudes and individual experiences is present in second-generation South Asian women. Conscious of the points raised by Littlewood & Lisedge and Ahmed, as well as of the internal conflicts that can occur in any community and family, I deemed it important to attempt to gain an insight into how my sample of 46 second-generation South Asian women described their life experiences as women of South Asian origin growing up and living in Scotland. This section of the interviews focused on educational experiences, employment, marriage and motherhood experiences. The women were asked about their personal goals and aspirations at different stages of their lives from being at school through to the present. The issue of how they perceived their own identity was also addressed.

My Interpretation and use of Acculturation

On the basis of this study involving South Asian women in Scotland and in Bradford, I see acculturation as a multi-dimensional process arising out of the interaction between ethnic minorities and indigenous majority groups. The absorption of values and practices of majority cultures and their implementation in the everyday lives of ethnic minority groups is diverse. I would categorise these processes as ranging from partial embracing and/or semi-embracing flexiblesand principally embracing pro-changers who I will call **Integrationists** and non-embracing no-changers who I call **Separationists**. However, the process of adaptation and change is not static, not written in tablets of stone and not irreversible. I shall quote in greater detail the views of the women in these categories but quote one women in each category at this stage in order to indicate the nature of such views and give a flavour of what they said.

Integrationists

(i)**Pro-changers.** There can be ethnic minority persons who semi-embrace a number of the attitudes, values and practices of majority cultures and live their life's according to these.

es1nd stated

> *"You are a woman, a wife, a mother-in-law. That's it, careers don't exist. There has to be changes, and the biggest change has to come in men's attitudes but the biggest changes will come from the women. The biggest thing is choice. It's the women born here who are the biggest hope for change. Men have it too good really. In our culture the men say that women should stay at home. Women are not allowed to have relationships with the opposite sex before marriage. I don't agree with all that, it's not true anyway.....*(this woman went on to explain that she had been taken out of school despite her wishes to stay on and seek academic qualifications) *I didn't want to be taken out of school. I didn't think it was right, it was unnecessary but I suppose you took for granted what your parents said....We were duped. I read the religious*

scriptures and they said nothing about things like that. The founder of Sikhism said that men and women were equal within the family.

People think that more freedom means accepting western ways but it's not as if women are going to have 10,000 affairs or anything like that. To them you cannot be a wee bit western, it's all or nothing. Now it's rebellion and some kids are going off the deep end. Some are running away, they can't stand the strictness. Some young women can't stand the strictness. People tend to gossip and you are under more scrutiny- it stinks. I don't think the restrictions on the women are necessary, women are always the ones worrying. Men just say 'watch what you're doing, we don't want people talking about us'. If anything goes wrong it's the woman's fault. That's wrong and it doesn't work, it can't , not now."

Despite criticisms of certain aspects of their culture and tradition, and the strength of their feelings on the need for a change in women's roles, all the women in this group wanted to maintain certain features of their culture and tradition. These aspects wanting to be maintained were language, diet, religious festivals and dress. The women expressed a desire to pass these aspects onto their children in the hope they would maintain them. They were emphatic on the need for equality between the sexes and that maintaining the above aspects of culture and tradition would be done with women having more of a say. The women believed their children should have choice and that as parents they would not force them into adopting cultural traditions their children were not willing to accept.

I would describe the second grouping in the who adapted as a consequence of the acculturation process in the following way :

(ii)**Flexibles**. There can be a movement towards certain attitudes, values and practices found in majority cultures whilst, at the same time, keeping a firm hold on values and practices akin to their culture and religious heritage. What I would describe as process of partial -embracement. The views of em2d is given as an example.

em2d said

> *"I'm a Muslim and I take my religion seriously. I want to keep my dress, my language and my diet, that is the 50% Asian side of me. I still have a strong identity, a strong pride and strong beliefs. The British side is my mind, my thoughts, being outgoing. I'm more outgoing than others, probably because I was born here. The ones brought up here are more outgoing than the Asians brought over. When I went to Pakistan I didn't fit in 100 per cent , not even 50 per cent. School life is the big influence. You talk to different people and you are with them for ten to twelve years. I spend more time with them than you do with your parents. That's the difference between us and our parents. We did our growing up here."*

Separationists

I outline the second grouping **No-Changers** in the following way: There can be a wholesale rejection of the majority cultures values and practices and a powerful embracing of their particular cultural and religious values and practices. Non-embracing in terms of majority values and practices. The example of gm10d is provided.

Women in this category were adamant about the importance of rigorously maintaining religious and cultural traditions, as **gm10d** stated

> *"I'm proud of being a Muslim and proud of my heritage. I still identify with Pakistan very strongly even though I haven't lived there and only visited on holiday. My parents brought me up in a certain way, okay it was strict but it didn't do me any*

harm and I'll do the same with my children.....yes and my daughters Look at all the problems out there anyway, so why should we change?"

The above examples indicate diversity of outlook, values and practices. The consequences of the above processes vary considerably. For some the process produces no conflict and takes place with the support and encouragement of family and friends. For others change and adaptation raises some problems but, after discussion and negotiation, these problems are resolved. For some the mere desire to investigate majority values and cultures and contemplate adaptation can result in turmoil. The outcome of desired and actual change and adaptation with respect to majority values and practices is not necessarily influenced by the degree of adaptation/change or desired adaptation/change. Some can move 80% of the way in their adaptation and experience no conflict and negative repercussions. Some can move 5% of the way and experience conflict and dispute.

There are people who merely seek adaptation who experience conflicts which can remain unresolved, with the person unable to seek out alternative changes which they consequently resent. Some embrace certain adaptations, consequently resulting in conflicts and disputes which remain unresolved, or the conflicts can worsen. Some embrace major change and experience conflict but remain determined to see these changes through, despite the conflict. Others achieve major change with little opposition. The potential for conflict can be influenced by a number of factors, family attitudes, availability of support, and the content and nature of the adaptations and changes involved. As adressed in the conclusion of this chaptert, change and adaptation does not necessarily result in conflict. In addition, the process of adaptation and change is not a mono-dimensional process of movement towards or movement away from values and practices of majority cultures. It is a fluid, on-going process which is not irrevocable. For example, those who go on to embrace majority values and practices can, after a period of time, then go back to embracing some of the attitudes, values and practices identifiable with their particular religious and cultural heritage. This, can be

partial, mainly embracing, and in some occasions all embracing where the individual embraces attitudes, values and practices of their particular ethnic group much more strongly than before. Ultimately, the potential for change, either way, is a central part of the acculturation process.

These factors are crucial in understanding the acculturative process from the individual woman's point of view and equally important in assessing the nature of acculturative life events and their impact on the woman's mental health. I have included interview material here at this stage in order to clarify and put into perspective the significance of the acculturation process, especially its link with significant life events and mental ill-health, specifically depression.

Data Analysis: Identity and Marriage

Three main themes emerged from this section of the interviews with regard to the acculturation process (i) the role and expectations of women in the South Asian community (ii) the issue of marriage (particularly relating to the women's children) and (iii) the women's own perceptions of their individual identity. The question of the role and expectations of women in the community emerged as a powerful and significant factors.

Integrationists

Group 1- 'Pro-Changers' (19 out of 46 Interviewees)

Pro-changers on Identity

gm5d said

> *"Men get to do what they want, so women should get to do what they want too. As long as it's guided by Islam, women can do what they want. Some people take it the wrong way ,though, and keep women down. Well, it cant work.*

When I was growing up there were far too many restrictions. They were cultural, not religious, all that stuff about girls and the way things should be. That is custom and culture, you know 'women shouldn't do this and women shouldn't do that'. The husbands are treated like lords and kings. First it's your parents, your father, then your brother and then your husband. It is hard to accept, I was told that when I got married I could do what I like but it's not happened. Women's lives are based around men - even today. Why should it be? It should be half and half.... when I was between 16 and 20 I wasn't allowed out. I accepted it. I didn't know any different but looking back it makes me angry. I like my traditions as long as it's not things that men have made up like women should stay at home, do the cooking, look after the kids. In that sense I'm not traditional at all .

This group were the most outspoken on the need for change in their community with particular reference to women's roles. In their opinion there was a significant imbalance regarding the opportunities for Asian women compared with Asian males. They wanted existing inequalities between the sexes to be eradicated. The women believed that some of the traditional roles undertaken by women in the past were no longer suitable in meeting the needs, desires and interests of Asian women today and in the future.

Despite criticisms of certain aspects of their culture and tradition, and the strength of their feelings on the need for a change in women's roles, all the women in this group wanted to maintain certain features of their culture and tradition. Key aspects wanting to be maintained were language, dict, and religious festivals and dress. The women expressed a desire to pass these aspects onto their children in the hope they would uphold them. They were emphatic on the need for equality between the sexes and that maintaining the above aspects of culture and tradition would be done with women having more of a say. They were unanimous in the feeling that their children should have choice and that, as parents, they would not force them into fulfilling any cultural tradition they were not willing to accept.

'Pro-Changers' on Marriage

gm4nd stated:

> *"With my daughter I would say as long as you can convince me you are happy, you can marry anyone. I have two daughters and I would hate them to go through what I've gone through."*

gm5nd commented

> *"When my parents had their marriage they had to accept it. Now, because there is more contact with boys you can fall in love. I believe love is the key aspect.....there was*

that case of the annulled marriage in Glasgow. The parents must have so much shame and hurt, their honour is down the drain. I think , good for the girl, though. These girls are treated as outcasts but they are paving the way for the future. Parents will think twice about forcing their children into marriage and that's good. I would allow my son to marry anyone, from China or anywhere, who cares! As long as he's happy. "

gh4d stated:

"*On marriage, pressure was always to the forefront. Before, it was arranged and that was it. That worked because women were brought up to obey. Now it's changing, more women are working and think for themselves. It works now because women are more prepared to disagree and say 'no I don't want to marry him'. There is flexibility now, you get to know the person more now and that is how it should be.*"

'Pro-Changers' on Identity

Eight women in this group described themselves as Scottish Asian, five Scottish Muslims, two Scottish Hindus, two Scottish, one Asian and one as Scottish Sikh.

gm4d commented-

> " *I am a Muslim and for me my religion is an important part of my life because of the way I have been brought up. I'm a strong believer but not 100%, my parents are more like that, it guides everything they do but not with me. I like my traditions as long as it's not things that men have made up, like women should do everything men say: cooking, staying at home, looking after the kids. These things are unfair. People who say that are not religious anyway . I am Scottish because this is where I was born and that too shows.....like in the way I speak, how I mix with people, how I bring up my children.*"

gn3nd made the following comments

> *"I don't think I'm different from other Scottish people. My skin may be different and when I dress up for weddings and that I'm different but this is my home. Some of my friends have gone back to India but I wouldn't feel at home there. Because my parents were born there I will always have that Asian identity, I wouldn't want to lose that.*

es2nd said

> *"I see myself as a Scottish Sikh...My faith is with me always, when things aren't going well, my religion helps me pull through. ..... I would want my kids to see themselves in the same way. Scotland is my home; I was born here. Our relatives see us as British, you get called British when you go over there. But I'm Scottish, I wouldn't want to live anywhere else."*

Group 2 - The 'Flexibles' (17 out of 46 Interviewees)

The 17 'flexibles' were not as strong on the question of women's roles as the previous group but nevertheless expressed a desire for modifications in the maintenance of their culture and traditions. This stemmed from a genuine desire to see them maintained and from the pragmatic view as put by one an Edinburgh Muslim woman that '*if you force them, they'll turn their backs on it*".

'Flexibles' on Identity

gm10nd said

> *"I'll try not to do the same with my daughters as my parents did with me. There is a big difference, though. The fact is my kids won't accept what I accepted. The girls will be treated the same as the boys. I've got my son doing housework and that, they'll be treated the same.... There will be a less formal way with the customs and traditions. I want them to keep them , that's very important. But I want them to be themselves."*

eh3nd noted:

"The fact is that we are living in Scotland and we have been all our lives. Our parents' background will always be with us, I really hope so, how can we escape it?.....It is there in the way we dress, our religion, our appearance. I want to keep that and want my children to as well, but that is a voluntary thing. You force children to do anything these days and look what happens. You can't tell them but you can encourage them ."

'Flexibles' on Marriage

gm9nd

"My children will have a choice in marriage. You are seeing more Asian divorces and girls running away to avoid marriage. I would want them to marry someone from our background but to be happy they must have more choice..

gh1nd

"On marriage, pressure was always to the forefront. Before, it was arranged and that was it. That worked because women were brought up to obey. Now it's changing, more women are working and think for themselves. It works now because women are more prepared to disagree and say 'no I don't want to marry him'. There is flexibility now, you get to know the person more now and that is how it should be."

em1nd

> *"My daughter's marriage, I've thought about it a lot. When I was younger I would have said marry who you want. But mixed marriages are difficult- same- background marriages are hard enough...My view of arranged marriage is changing, I would probably like it to be arranged but with the consent of parent and daughter."*

'Flexibles' on Identity

In this group, six women described themselves as Scottish Muslims, 2 as Asian, 2 Scottish Sikh, 2 British Asian, 3 Scottish Asian and 2 were not sure.

gm11nd believed

> *"I see myself as a mixture of all societies. I was taught certain things at school and had to adapt. I'm a Muslim and that is very important part of my life, it gives me satisfaction. it is part of who I am, it guides my actions. So do other things though, but my faith plays a big part. I was born in Scotland so Scotland is my home, my kids are more Scottish because of their upbringing".*

Separationists

'No Changers' (10 out of 46 interviewees)

'No-Changers' on Identity

A Glasgow woman **gm1d** stated

> *"I am Pakistani . When I was at school people called me 'Paki' and said things like 'what are you doing here'. No matter how hard you try people will never accept you as Scottish . My kids are Muslim, they think they are Scottish but people still call them 'Paki'. When we moved house the people in the tenement were horrible to me, they were white. If anyone came to my house the neighbours would start swearing at them, they also gave the children a hard time. I often had to call the police who warned them but I felt they could have done more. People say there is no racism here, that's rubbish, it is all over."*

gm12nd

" *It makes me angry the way Muslims in this country are shown on TV and in the papers, you would think that the rest of the world is perfect. I am the way I am because I think it is for the best for myself and for my family. I know some people feel you have to be a bit more western, but why? If there was something out there better, maybe I would have changed but there isn't.*"

The ten people in this group were of the view that any changes would weaken their identity. They were strong on the need for maintaining religious traditions as one Glasgow Muslim woman stated-

'No-Changers' on Marriage

gs1nd said

" *Marriage is such an important part of our lives that it cannot be left to young people to decide for themselves. How can someone just out of their teens make a decision on their own that will affect the rest of their lives?..... Look at the divorce rate in this country, there are divorces in our community but they are tiny compared to the rest and that is because we put a great deal more thought and time into it.*

"*It worked for me and my sisters, it's the best way, I had no problem with it. I trusted my parents' judgement and they were right. I know my daughter feels the same way about us arranging her marriage.*"

This section of the interviewees held the opinion that the arranged marriage, organised by both sets of parents, was the most effective way of ensuring a 'stable' marriage of two persons. In that sense they could be described as having a strong traditional approach to marriage when it came to their children.

In this section, two described themselves as Muslims, two Pakistani, two Scottish Pakistanis, two British Muslims, one Scottish/Pakistani Muslim, one Pakistani Muslim.

What emerges from this data is a picture indicating the heterodox nature of the South Asian community. The findings in my study appear to back up the findings made by social scientists who have studied or have knowledge of the groups who participated in this research. One important element which lay behind several responses, not just those quoted above, was the effects of racism, which although not universally experienced by the interviewees impacted on a number of interviewees and, consequently, on their views and outlook.

The Impact of Racism

An overwhelming majority, 33 out of 46, identified themselves as part Scottish, although only two referred to themselves entirely Scottish. Apart from a desire to maintain aspects of their Muslim, Hindu, or Sikh heritage, another reason given for the women not describing themselves as solely Scottish was the consequences of racial discrimination. This phenomenon was raised by six women (13% of the sample) when they discussed their own identity. The discrimination they faced meant they could never see themselves as solely or part Scottish. The criticisms of assimilation theorists for not recognising the possibility of hostility in receiving societies towards ethnic and religious minorities seems a valid one. The impact of racism on the acculturation process needs to be considered. In this study 13% of the sample, across all the three main groups identified, stated that they experienced racial discrimination in various forms. This phenomenon is a factor in the acculturation process because those experiencing it may feel that attempting to integrate may be pointless. Does this mean these women become separationists? In my opinion, no. The women who mentioned racism stated that it did affect the way they described themselves but that although they might not be accepted they wanted to adapt some of the roles and values associated with the dominant white majority. They all recounted incidents of direct racial abuse. Racial incidents can turn into a significant life event, and their role as a variable in depression needs to be considered. This is, however, a significant and contentious issue and will be addressed in depth in chapter 4.

Conclusion

A clear majority of the women interviewed in my study, whilst viewing their outlook and values as different to those of their parents, nevertheless remained largely anchored to their Muslim, Sikh, Hindu or (in their words) Asian identity, although the strength of these attachments varied. It appears that a majority of the interviewees, 36 out of 46 interviewed, had an Integrationist outlook simultaneously involving integration with and differentiation from the majority culture. It was significant that 31 of the interviewees chose to describe themselves as part Scottish and two solely Scottish. Although many expressed pride in their Scottishness, the overwhelming majority of interviewees rejected the notion that their Scottishness was at odds with their Muslim, Hindu, Sikh, or Asian identity. The Integrationists, (including both the 'pro-changers' and 'flexibles') viewed interaction with indigenous majorities in a positive rather than a negative light, seeing the attainment of certain aspects of majority attributes in an additive rather than a subtractive fashion and leading, not to a rejection of their minority group identity and values, but to the combining of various aspects of both their own and the indigenous majority's cultural attributes. I believe that the 'pro-changers' represented a modified version of what Berry's acculturation model called 'Integrationists'. They favour daily interactions with indigenous majorities and, whilst they wish to maintain aspects of cultural values and identity associated with being Muslim, Hindu, Sikh or Asian, wish to do so in a modified form that involves taking on selected values and behavioural traits associated with indigenous majorities. They were not, however, willing to accept the traditional ideals of the role of women. In that respect they wanted to see a change in their heritage. The 'flexibles' were less strong on change and probably are more directly in line with the Integrationist definition according to Berry's model.

In my opinion, this demonstrates that the acculturation process does not inevitably lead to the wholesale rejection or replacement of old values, behaviours and traits as assimilationists believe.

The 'no-changers' on the other hand saw no benefits in adopting any aspects of the beliefs and behavioural traits held by indigenous majorities. This group could be described as most closely

associated with a modified form of what Berry's model calls 'Separationists' i.e. they have a strong desire to hold onto their cultural values without any change. They do not meet Berry's criteria completely however as they do not, indeed cannot, avoid contact with the host culture. This grouping contained the most religious individuals in the study, and all were Muslims. The interpretation of and devotion towards their religious values, coupled with their unease about the majority culture, influenced their views in rejecting behavioural traits and values associated with the majority population.

The heterogeneous nature of the South Asian community is clear but so too is the heterogeneous nature within the individual religious groupings as demonstrated by the comments from Muslim women. This is not surprising. Particular identities are not stable, despite common religious, traditional and cultural values. Instead they change according to different forces operating on them. The actual process of migration, as Werbner (1990) points out, is necessarily a dual process: of expansion and consolidation, of cultural probing into the wider society, and revitalisation of a group's own culture, of expanding beyond the boundaries whilst simultaneously re-drawing boundaries. With regard to the general theories of ethnic minority adaptation processes, the majority in this sample expressed a desire to acculturate to specific aspects exhibited in dominant majorities without wishing to assimilate.

A crucial difference between these South Asian women and their parents appears to be that socialisation from an early age has taken place entirely in Britain and at a time where in the majority population traditional concepts of a woman's role in the family and the nature of the family unit have been questioned and undergone significant change. Second-generation women are, therefore, potentially more open to the pressure of these various social forces that operate to influence outlook than their parents were. They are brought up in an environment, the home and immediate community, that preaches alternative values to many of those found in the wider society. Both operated to shape their outlook and, not surprisingly, some opposing values will clash. In redefining their cultural identity, many second-generation South Asian women do so differently from their parents and stress

western values such as the equality of the sexes, greater freedom of choice in matters relating to marriage and occupation, and freedom of social dissent.

The duality Werbner (1990) refers to, operates despite the apparent incompatibility of opposing values and ideologies and reflects a pragmatism on the part of those in the community who view their cultural and religious traditions as the core of their identity rather than as a rule-book put into practice to govern their every action. In the instances where they are interpreted as a rule book, however, this can result in conflicts for some South Asian women. As this study will demonstrate, some women in this position are now finding that roles assigned solely on the basis of gender can be restricting, which can result in traditional gender-based roles being challenged and new roles that better suit the individual's own values and outlook being sought. It would appear from a significant number of the women interviewed in my study that gender inequalities, relating to the role of women in the family and wider community, can become an area of conflict much more so than the catch all and simplistic phrase 'culture' and, at this stage at least, it is these inequalities that are more at risk than the abandonment of all ethnic traditions and values in the interactions between South Asian minorities and indigenous majorities.

I would contend that my own and other studies suggest that second-generation South Asian women, in the main, are likely to adopt an Integrationist attitude as a result of the acculturation process. This flows from their everyday socialisation experiences from which they draw upon aspects of South Asian cultural traditions and the surrounding British social and cultural practices. This was less likely with their parents, for reasons already explained, although, importantly, as Brah (1978) points out, they too can undergo change as a result of their new settings. This change can show itself in their attitudes to their children's upbringing, where they may feel that it is not possible for their children to have the same upbringing as themselves. Therefore, although their own personal attitudes to integration may not be as strong as their children's, they favour such an outcome. This is less likely to lead to conflicts, making the acculturation process for second-generation women less stressful. The same principle can be said to apply in relation to the woman's spouse. Where the spouse has an Integrationist attitude, the prospect of conflict is reduced, again making the acculturation process less

stressful. On the other hand, where the parents or spouse of second-generation women have separationist attitudes contrasting with the women's Integrationist views, conflicts, particularly over the position and role of women, are a significant possibility. In such situations these conflicts can make the acculturation process a stressful experience and, as a significant life event, this can impact on the mental health of the women experiencing such acculturative stress. What must also be considered is the possibility that some parents and spouses may have Integrationist attitudes themselves, but do not believe these are appropriate for women who should, in turn, keep strictly to the traditional roles laid down for them. Once again, this increases the likelihood of conflict, and of making the acculturation experience a stressful one. As I will demonstrate in chapter 4, this does not automatically result in a depressive illness, as social supports can buffer such stressful events. Nevertheless, the stresses of the acculturation process for second-generation South Asian women are an important variable when considering the nature of life events in the onset of depression in second-generation South Asian women .

Chapter 3:Methods and Methodology.

Introduction

This chapter describes the methodological approach adopted in this study as well as addressing the contentious research issues involved in a study of this nature. It begins by looking at some of the problems the researcher had to contend with as a white Scottish male working with South Asian women. I acknowledge the existence of power imbalances that can often arise in this type of ethnographic research and explain that imperfections in data gathering, especially the interviewer's part, must be discussed. I conclude, however, by stating that in studies of this nature there often lies a questionable presupposition- that the veracity of interviewees' comments is dependent on whether or not the interviews are carried out by same-sex and/or same-'race' interviewers.

The chapter then moves on to detail the study's design and address the methodological approach to the measurement of life events and social support. I explain the reasons for using a depression scale to record the presence or absence of depression. In doing so I look into the questions of cross-cultural research and the appropriateness of using mental illness labels, developed mainly in western psychology/psychiatry, among ethnic minority communities. Flowing from this, the suitability and reliability of mental health scales to identify mental illnesses such as depression in the sample is discussed. The chapter ends by outlining the actual interview process itself, what issues were addressed and why, and discusses the nature of the interaction between myself and the women interviewed.

Initial Research Concerns

At the outset of my proposed research I had to contend with a major issue: was it possible for a white male to organise and personally carry out interviews with South Asian women? It was a question I was to be asked on a number of occasions. Conscious of this, the first thing I thought should be done was to discuss my research intentions with South Asian organisations, South Asian women's groups and health and welfare professionals working with South Asian women.

I contacted a number of South Asian organisations and made appointments to meet South Asian community workers, South Asian health professionals, South Asian women's groups and national

and regional mental health organisations in Glasgow and in Edinburgh. Following a series of meetings and discussions on my proposed research a number of organisations agreed to support my research. These included Shakti Women's Aid (Edinburgh), The Confederation of Indian Organisations, NKS (a South Asian women's organisation in Edinburgh), the Scottish South Asian Action Committee, Saheliya (a mental health project for Black and ethnic minority women), the Glasgow Association of Mental Health and the Scottish Association of Mental Health. A number supplied me with letters stating that research of this nature was important and, after discussions with myself, judged I was sensitive to the issues to be investigated. (See Appendix 1 for sample copies of letters giving support to the intended research).

An additional question I had to address in focusing on depression in a minority ethnic community (where a number of social problems associated with depression such as family disputes, domestic violence and marriage breakdown would possibly emerge) was whether this would create a negative picture of this community. Consequently, there existed the possibility of stigmatisation. I considered this and believed it would be a worse alternative if I chose to ignore these problems for fear of stigmatisation. On this matter I concur with Wilson (1993) a black woman who wrote on the subject of black women and domestic violence. Wilson argues that, while opening up the debate may expose her community to negative stereotyping, ignoring the problem can also be damaging. Speaking to the Guardian (13/9/93) Wilson stated "*The belief that we shouldn't wash our dirty linen in public needs to be changed. ....If we don't talk about it, what are woman supposed to do with the emotional baggage we carry as a result* ". With respect to my own study, the fact that a range of South Asian, Women's and mental health organisations gave the proposed study their backing was testament to this. As well as giving the researcher's confidence a boost, this backing was to prove very important in the fieldwork, particularly in relation to my own credibility when approaching certain groups through whom I would work in gaining access to my sample.

Before undertaking the interviews I applied for and received ethical permission for the proposed research from: The Southern General Hospital Ethics Committee (Glasgow), The Victoria Infirmary Ethics Committee (Glasgow) and The Ethics of Medical Research Sub-Committee (Psychiatry and

Clinical Psychology) Edinburgh. All were satisfied my proposed research methods met their ethical guide-lines.

In terms of how I would gather my data, I believed that an ethnographic approach would be the best way to address the issues I wanted to investigate. I wanted to speak with the women. Although ethnography is a contested method of data collection, I was attracted to one definition of ethnography as being "*actively situated between powerful systems of meaning. It poses its questions at the boundaries of ...cultures, classes, races and genders... it describes the process of innovation and structuration, and is itself part of these processes*" (Marcus, 1986:2-3).

Although I had received support for my study from South Asian organisations and South Asian health workers, meeting with South Asian women and the nature of the interview process with myself as a white male and all the potential issues of power affecting the interview process, have to be addressed. I intend to do this here firstly by looking at the process of ethnography generally, and secondly by looking into the questions of cross-gender and cross-'race' research.

The Ethnographic Approach

Those who are critical of aspects of ethnographic research, for example Marcus (1986), contend that such an approach is enmeshed in a world of enduring power inequalities which, consequently, renders a great deal of such open to question. Marcus (1986), in my opinion has a strong point. A not inconsiderable amount of academic research on black and ethnic minorities is of a dubious quality and, historically speaking, as highlighted by Littlewood. There are many consequences of such research, one is the emergence of the "*indigenous ethnographer*" (Ohnuki-Tierny, 1984), considered as '*insiders*' who carry out research on people from their *"own race and culture"*. This is in my opinion a very welcome step forward. But after reading her book "*Death Without Weeping*", an ethnographic study into violence on women in Brazil, I found myself agreeing with some of Scheper-Hughe's arguments on ethnographic research. Scheper-Hughes (1993) believes that many young researchers, sensitised by, among others, the writings of Michel Foucault (1975; 1980; 1982) on "power/knowledge", come to think of ethnographic fieldwork as an unwarranted intrusion on the

lives of the vulnerable and threatened people with the ethnographic interview likened to the medieval "*inquisitional confession*" as suggested by Ginsberg (1988). Growing weary of these post-modernist critiques Scheper-Hughes is inclined towards a compromise that calls for a *"good enough"* ethnography. Scheper-Hughes believes we cannot rid ourselves of the cultural self we bring with us into the field, any more than we can disown the eyes, ears and skin through which we take in our intuitive perceptions about the world we have entered. Nonetheless, we struggle to do the best we can with the limited resources we have at hand - our ability to listen and observe carefully, empathetically and compassionately. In so doing, Scheper-Hughes concludes that the answer to contentious issues in cros-'racial' research is not a retreat from ethnography altogether or to an ethnography written only by native sons and daughters, as they often turn out to be equally distanced from the interviewees in terms of class, education, and experience. Rather, the answer is an ethnography that is open-ended and that allows for multiple readings and alternative conclusions (Scheper-Hughes, 1993).

Flowing from this approach and, using a metaphor from Bakhtin (1981), the ethnographic approach becomes more dialogue than monologue, and subsequently knowledge may be seen as something produced in human interaction and not merely "extracted" from "naive" interviewees unaware of the hidden agendas of outsiders. I would contend that there will ineviabely be different versions in any story told, and that it is up to the listener to piece together for him/herself the version of events they, for the time being at least, cocurs with their own views and perceptions. In saying that, no one reads from a neutral or final position. This obvious point is often violated in what are heralded as the "new" accounts that purport to "set the record straight" or to fill a gap in "our" knowledge. Such approaches are crucial in develpoing an understanding of the divergent proceses at work. At the same time, I concur with Marcus (1986), who believes that the diverse 'rules' for ethnographic practice do not necessarily encourage "better" cultural accounts., the criteria for judging a "good account' never having been settled.

In highlighting the divergent views that can be present in ethnograhic research, in particular relating to who conducts research on gender and race. There have long been areas of contention in

ethnographic studies. Given the nature of my own research the next section will adress cross-gender and cross-'race' research, in particular those sections that have been criticised.

Cross-gender Research

A feminist approach, defined by Gelsthorpe & Morris, (1990) as accepting the view that women experience subordination on the basis of their sex and working towards the elimination of that subordination, can inform research in two ways. Firstly, by the choice of topic and secondly, by the way the research is carried out (Gelsthorpe, 1990; Reinhatrtz, 1992). Prominent feminist writers such as Oakley (1981) and Finch (1984) believe that a qualitative approach is the most appropriate method of research when working with women. In particular, their approach to research suggests that female researchers can develop a special relationship with the women they are interviewing due to their shared, gender-based experiences. For some, the desire to make women visible has led to the absolute commitment that research should be '*on, by and for women*'. This approach has been criticised for the extent to which it excludes men and the way in which the research process and choice of methods have been highly prescriptive in laying down what is and is not acceptable (Gelsthorpe, 1993).

One opinion among feminist researchers is the view that women researchers can "empower" the researched, and that analysis based on "shared gendered experiences" will emerge with a more complete and "more truthful" account of the researched women in question. Ramazanoglu (1990) for example believes that the development of successful feminist sociology must be based on the "empowerment" of the researched. Taking issue with this Scott (1992) believes that any approach which "disempowers" the researcher will lead to a "lowest common denominator approach" leading to the researcher silencing him or herself. Opie (1992) voices concern at the way some feminist researchers impose their ideology on the researched in their eagerness to empower them, flowing from their preconceived notions of empowerment. Opie states " *I have become conscious of the limitations of feminist interpretations. Although at one point they are liberatory because they open to inspection what has previously been hidden, they are also restrictive in the sense that they can appropriate the data to the researcher's interests so that other significant experimental elements which challenge or partially disrupt that interpretation may also be silenced.* " (Opie, 1992:52).

Lorraine Gelsthorpe (1993) notes that a distinctive feature of much feminist research is that it generates its problematic from the perspective of women's experiences. Consequently, some feminist writers (notably, although not exclusively radical feminists) argue that men's biology and/or psychology precludes them from becoming feminist or doing feminist research. Pateman (1986), for example, notes that there is a "*womanly capacity that men do not possess*", while for Gilligan (1992), women's voice is "*in a higher register*". What is implied here is that women are deemed to possess a privileged means of knowing and as a result, a superior knowledge. For Gelsthorpe (1993), this smacks of essentialism. While accepting that women do share certain experiences based on gender, Gelsthorpe believes the idea of a "shared consciousness" is problematic in that it implies a common unity among women generally. She states that this clearly is not the case with age, class, and race distinctions cutting across the idea of common gender experiences, dividing women just as they do men and as a result, the 'conscious experiences' of women vary greatly.

Gelsthorpe (1993) believes that a less limiting definition of feminism is one that involves the recognition that women are oppressed on the basis of their sex and attempts to end that oppression. Therefore, despite the fact that it is women who directly experience that oppression to varying degrees, men can recognise its existence. Men cannot be feminist in the sense that women can be, but they *can* hold a feminist perspective that is sufficiently sympathetic to women's position. Gelsthorpe goes further and states that to argue that men cannot do feminist research would be like saying only teachers can research teaching practice or other teachers, or only prisoners can study prisoners. Echoing Scheper-Hughes, she makes a strong point when she says that the researcher is very rarely in exactly the same position as the research subject in terms of class, culture and social experiences. For Gelsthorpe, the ability to contribute to the feminist understanding is not something achieved by the virtue of being female, "*the 'women's experience' from which the feminist problematics arise need not necessarily be the experience of the researcher herself/himself*" (Gelsthorpe, 1993; 90).

In emphasising this point, Gelsthorpe draws attention to a study by Woodward & Chisholm (1981) who carried out research on the lives of female graduates with children whose husbands were in

employment. Woodward and Chisholm believed that they both had little insight into the women's experience of marriage, parenthood or husbands' employment. They saw themselves as young career-minded feminists. They argued, however, that their research did not suffer because of this, but rather it was enhanced by the fact that the women had to explain in greater detail the reality of their lives. (This last sentiment is something I can relate to as someone coming in from the outside. A similar situation obtained in my own research).

In relation to the specific issue of research on women by men, Sandra Harding (1987), Nancy Hartsock (1987) and Dorothy Smith (1988), among others, have argued that feminist epistemology is more than women's viewpoint. It is a method, a mode of enquiry which lays emphasis on experiences of women and on the actualities of their everyday worlds. I believe my methods and approach to my own study were in line with these sentiments.

The question of white people carrying out research in the black and ethnic minority community is another contentious issue in research, one that has recently been opened up for discussion and debate. The debate has been fuelled in recent years by critics who argue that research on 'race' and health has suffered from a number of problems which I shall now summarise before going on to address the question of cross-'racial' research.

'Race' and Health Research: Where it is "Going Wrong."

Webb (1982) contends that literature on 'race' and health often contains widespread bias, mirroring the interests of health professionals and 'at odds' with the priorities of ethnic minority communities. Harvey (1990) states that orthodox research on 'race' and health downplays the disputed questions of power relations, including racism, which must be central to any critical research. For Pearson (1983), there operates a dominant research focus on 'culture' at the expense of the concern with power relations, including racism, echoing Lawrence (1982) who referred to a tendency in researchers and academics to tackle any problem except 'the burning problem of racism'.

Drawing on the work of Pearson (1983), who stated that black people often become objects of more and more 'white research', Stubbs (1993) states that at its simplest, Pearson's argument raises questions about the role of white researchers studying ethnic minority health both in terms of ethics and research validity. For Stubbs (1993), the role of white researchers in 'race' and health research should be under greater scrutiny than it has been until now.

Ahmad (1993) notes that the literature in the field of ethnic minority health demonstrates a '*naive empiricism and cultural reductionism*' that would not be permitted in the different branches of medical or social research. Ahmad believes that the field of 'race' and health needs to be radicalised and politicised. To be 'credible and useful' a researcher in this field needs to be familiar with the history and politics of 'race' and also the fact that, in his opinion, minority cultures possess a political existence quite apart from having distinct cultures (Ahmad, 1993). Stubbs (1993), believes that anti-racist analyses and practices would bring 'race' and health research into a radical political arena and that such an approach would have as its starting point not 'culture' but racism.

The critical views held by those quoted above are applied to all aspects of 'race' and health research. A great deal of such criticism has been aimed at those conducting research on mental illness in ethnic minority communities. Fernando (1987;1990) for example contends that racism is a key factor in the development of mental illness in British South Asians. For Fernando, although racial prejudice is an obvious stress to anyone who experiences it, institutionalised racism is much more than that, its damage being subtly destructive to the individual. Furthermore, any attempt to understand social phenomena related to mental health problems in Britain's black and South Asian communities must first understand that racism plays a major factor in their lives. Fernando believes most research ignores this and he and others, not without good reason in some cases, cite past research carried out on health and ethnic minorities. What is the basis for such a stance?

'Race' and Mental Health Research

As psychiatry was developed in a western cultural framework by (mainly) white people, the significance of cultural and racial considerations becomes obvious and important when the speciality is practised among people who do not conform to this culture and/or are identified as not being white (Fernando, 1990; Littlewood and Lipsedge, 1989).

Littlewood and Lipsedge (1989) point out that, historically, scientific theories relating to the health and behaviour of black people always demonstrated the superiority of white people and the impossibility of black people improving their own (biological) deficiencies. Critics of mental health studies on ethnic minorities, especially black and South Asian groups, contend that, as twentieth century psychiatry developed, racist ideas were incorporated into it. These included views about the alleged inferiority of black people with regard to brain size, psychological immaturity, and poor emotional differentiation (Littlewood and Lipsedge, 1989).

Lawrence (1982), suggests that the alleged inferiority of the black person's brain, personality and intelligence has been gradually supplemented by "culturalist" theories quoting defective kinship systems, marital arrangements and child bearing practices of black communities. Consequently, by focusing the problem of racism on culture, both the power structure within psychiatry and the power of white over black is maintained because the remedy is looked for in 'alien cultures'. These views are in my opinion important to bear in mind. As well as recognising the pernicious influence and nature of racism, when conducting research in black and South Asian communities, a social science researcher should be aware of the historical and present deficiencies and at times outright bias found in ethnic minority research. However, does this mean that research on ethnic minorities should be restricted to those from within these communities, or is it possible that only "good" research can be carried out on such a basis? I aim to demonstrate that this is not necessarily the case.

Cross-'racial' Interviewing: The Case For and Against

Douglas (1992) argues that white women's accounts of black women's experiences are flawed because of the "*assumption that the shared experiences uniting women outweigh the difference in*

relation to race and class..... for Black women racism is paramount " (Douglas, 1992: 39; quoted from Bowes and Domokos, 1993:6), the moral here being that white people do not experience racism and therefore cannot understand black women's experiences.

Drawing on Oakley (1981), who stated that research subjects are not simply informants and should be treated with respect, Bhavnani (1991) notes that imparting information about herself (age, marital status, experience of racism) is one means of focusing upon power inequalities during research. Bhavnani believes that whilst power inequalities in research do exist, the socially ascribed characteristics that such inequalities flow from can be uneven and can be 'controlled for' by women interviewing women, blacks interviewing blacks, etc. Bhavnani contends, however, that if such a phenomenon is accepted, rather than side-step the issue of power we should address its functioning in research by recognising that the balance of power can be both inverted and subverted. This view is based on the experience of her own study with white and black working class youth. As a black woman researcher defined as socially middle class, the interviews with these youth were "inscribed within multi-faceted power relationships which had structural domination and structural subordination on both sides".

Bhavnani (1991) notes that although the white interviewees in her study of young people and politics could not have encountered racism as their black interviewees had, the fact that some white interviewees had a similar social network, could result in some white interviewees encountering hostility because they were friendly with black people. In addressing the issue of power relations between researcher and the researched, Bhavnani (1991) notes the existence of power relationships between researcher and researched but states that power relationships between these two groups are also affected by 'socially ascribed characteristics' introducing hierarchical loadings of their own.

Following their own research on the health needs of South Asian women in Glasgow Bowes and Domokos (1993) state that to avoid the possibility "patronising racism", as suggested by some in the ethnic minority research field (Bowes and Domokos cite Kazi 1993) a "fissured" account is necessary and this should begin with the women's own views. On the basis of their own research, Bowes and

Domokos conclude that such an approach can often result in findings which challenge received wisdom, and draw on their own study as an example. In their most recent study involving South Asian women, Bowes and Domokos adopted their approach with the aim of reaching, in the circumstances, women's best accounts of their experiences and views of the world, expressed in ways most satisfying to the women themselves.

Concluding from their own study that South Asian women are "ordinary" health service consumers with "ordinary" problems, their needs not radically different, Bowes and Domokos (1993) believe that their fissured account demonstrates South Asian women challenging perceived wisdom in sociology and feminism. With regard to feminist approaches and in particular feminist sociology, they challenge the insistence on the primacy of gender and the purported homogeneity of the category 'women'. Furthermore, and somewhat contrary to criticisms of 'white sociology' and homogenising feminism, they also question the primacy of racism in shaping black women's lives.

Bowes and Domokos (1993) believe their study showed that women varied considerably in their experiences and assessments of racism. The variation can be related to individual biography to some extent, in that assessments of the importance of racism relate quite closely to the degree of direct experience of it, and to the extent to which women contextualised these experiences with reference to wider social processes. In these terms, only a small minority of the women interviewed saw racism as fundamental, and, in general, those who did so were referring to institutional rather than interpersonal racism (Bowes and Domokos, 1993).

As with Wardhaugh (1989), Bowes and Domokos argue that a white woman working with a black woman faces a particular challenge, the challenge being that as a white person in a racist society, she is in a position of power vis a vis black women. Thus the researcher must be alert to the ways in which the interviewing process may reflect the power structure and what the consequences of this might be. Furthermore, the white interviewer cannot share experiences of racism with black interviewees, and this may compound the difficulties. On the other hand, the advantage is that a white researcher is an outsider, and many women stated that they found it easier to talk with someone who

was not involved in the local community where gossip could be a problem with respect to a person's problems. (I found this in a number of cases with my own research, and shall address this in Chapter 3).

Bowes and Domokos (1993) note that in the end, every piece of data gathering must be a compromise between the perfect and the possible. What is important in the research account is that the imperfections in the data gathering approach, that is, its own fissures, are revealed, as part of the general revelation of competing voices. They argue for a more reflexive way of working in terms of research methods: firstly, in the sense of being more responsive to the people being researched, and, secondly, in the sense of greater self-consciousness on the part of researchers, who need to be conscious of their own involvement in the research process.

In the same way, as Gelsthorpe notes, it is dubious to talk of a "shared consciousness" among women given the many distinctions that exist. Is it then realistic to present an image of a black and ethnic minority community that has a similar "shared experience" and that therefore only people from these communities can carry out meaningful research on people of the same community?

I remain to be convinced concerning the image of a black and ethnic minority community that has a similar "shared experience". Although people from ethnic minority communities have the potential to share the experience of racism, to talk of these communities in this manner gives the impression of homogeneous communities bound together by racism. In my opinion this is to fall into the same trap as the "cultural reductionists" so criticised by Ahmed (1993): i.e. to suggest that phenomena, no matter how complex, can be reduced to a single factor. Based on her experiences of working with black and South Asian women in a women's refuge in London, Patel (1991) notes, there exists a "*simple but powerful myth: that ethnic minority communities are "homogeneous entities", without internal divisions and uniting in the face of racism". Consequently, "thinking at the heart of the anti-racist struggle fails to address the very real divisions of class, caste, religion and gender within our communities*" (Patel, 1991:219-220). I believe, partly on the basis of my own study and other works (see for example El Sohl's article "Be True to Your Culture: Gender Tensions Among Somali

Muslims in Britain") that the way in which inequalities within ethnic minority communities impact on people's life experiences can be easily ignored if a reductive approach is taken. Furthermore, does it necessarily follow that a member of an ethnic minority community will produce "better research"? That of course is in the eye of the beholder, but recent criticisms of South Asian TV programme makers from sections of their own community are suggestions of the extent of differentiation. In an article entitled "Sold out by media wallahs" Yasmin Alibhai-Brown criticises South Asian TV journalists for making, in her opinion, the "wrong type of programme" and believes these "media wallahs" do more harm than good as - "*they now produce scandalous and even racist programmes, which acquire authenticity because they are made by insiders.*" (New Statesman, 28/1/94). This demonstrates two things. Appointing indigenous researchers in the fields of journalistic or academic ethnic research does not necessarily produce the "right message", in part because there is no "right message", despite what some people would like to think. Rhodes (1994) notes that to restrict research on black people to black researchers is to risk a form of "academic marginalisation" in line with the relegation of black social workers to work only with black clients.

As Bowes and Domokos (1993) state, interpretation of research findings needs to be much more prepared to appreciate their complexity, and to avoid the reductionism entailed in single factor explanations. Similarly, Gelsthorpe (1993), in relation to her own research on racism, concludes "*what is of relevance here for the white researcher is the need to recognise that standpoints are constituted by politics, theory, theoretical reflexivity and choice (of site), not by biology, skin colour or ethnicity*" (Gelsthorpe, 1993:92).

I have spent some time on these arguments as given the nature of my research I am potentially implicated in some of the criticisms made by Ahmed and others. I shall now turn to my own study and the details of the study's design and my methodological approach.

The Research Design: A Comparative Study of Depressed and Non-Depressed Second Generation South Asian Women in Scotland

I decided to carry out a comparative study of depressed and non-depressed South Asian women in order to compare life experiences in both groups with a view to attempting to understand why members of one group developed depression. In saying this a number of possible research designs were considered. One possibility was a study comparing depressed South Asian women and depressed indigenous white women. This would potentially bring out any differences between the two communities. The ideal scenario would have been a study focusing on depressed second generation South Asian and indigenous white women and non-depressed second generation and indigenous white women. In reality this would have meant doing nearly 100 in-depth interviews which given the financial and time limits on myself as a PhD student was not, I believe, a practical option. As it turned out, setting up the interviews with the depressed and non-depressed women took the best part of one year of meetings, discussions, letter writing and a great deal of travel to and from Glasgow and within Edinburgh. Therefore, as the central feature of the study was to gather data on the life experiences of second generation South Asian women, I believe this to be best conducted by carrying out in-depth interviews with both depressed and non-depressed South Asian women. As there exists a very strong literature on depression among indigenous white women, a comparison of life experiences, although not ideal, was still possible.

The next question was how was I going to get access to my proposed sample? A list was compiled of South Asian groups, South Asian health and community workers, social workers, indigenous white health and community workers working with the South Asian community, and academics whom I wanted to meet for a general discussion. I kept a record of every meeting. A total of 45 people were met with either as individuals or as representatives of organisations, a number of them were met at least twice. This included eight South Asian community organisations, three ethnic minority women's groups, eight GPs , four psychiatrists, two Community Relations Councils (Lothian and Strathclyde), four mental health organisations, four health visitors, four university lecturers and researchers with experience of research in the South Asian community , two social workers, and a

representative from the Scottish Office. I also corresponded with a number of academics conducting research on depression in ethnic minority communities in England and the USA.

This approach was to prove beneficial. It added to and deepened my knowledge of various aspects of the South Asian community in Scotland as well as sensitising me to a number of issues and potential problems. It also helped me to identify the most suitable groups and individuals I should target in asking to co-operate actively with my research by helping me with direct access to my proposed sample. A list of 20 individuals and groups was drawn up. They were asked if they would actively co-operate with my research. In nearly every case I asked for active co-operation only after I had at least two meetings with the individual or group. I felt it was important these groups met me and could assess for themselves whether I was someone they felt comfortable working with. Only one organisation said no on the grounds that it was their policy not to allow access to the women they worked with. They did, however, support my research in principle and provided me with a letter saying so. Three other GPs stated that they could not co-operate because they either did not have the time or had no patients fitting my sample description. The remaining 16 individuals and groups agreed to co-operate with my study. Having secured the necessary co-operation to make the study viable, the next question was my sample.

The Research Sample

My aim was to carry out research on women who were either born in this country or came over to this country aged 5 years or less and had a primary and secondary education in this country. I felt this would be representative of second generation South Asian women whose socialisation experiences had been shaped in this country and not in the country of their parents. The women selected were aged 16 to 35 years, married with children. The sample was to be a reasonable representation of 'ordinary' South Asian women. By 'ordinary' I mean non-professional people living in what can be broadly described as working class areas of Edinburgh and Glasgow. I wanted the women to be users of services, not organisers or "committee people", i.e. local community activists. I was successful in achieving this with the exception of Bangladeshi women. Although a Bangladeshi women's group in Edinburgh supported my research, it is by far the smallest of the three groups in Scotland and my

categorisation of 16 to 35 year old married women proved difficult to meet. This was unfortunate and leaves the study slightly incomplete in terms of each of the major nationalities being represented but it was not for want of trying. Muslim, Hindu and Sikh women were included in numbers that were reasonably proportionate to their numbers in the population. I classified my sample into depressed and non-depressed cells which would relate to the size of the religious communities and regional density. The final breakdown for the depressed sample was: Glasgow Muslims (11), Glasgow Hindus (4), Glasgow Sikhs (2), Edinburgh Muslims (2), Edinburgh Hindus (2), Edinburgh Sikhs (2). The same breakdown was present with the non-depressed sample. The bias of numbers from Glasgow over Edinburgh was done on the basis of far greater numbers of South Asians living in Glasgow.

My Approach in the Interviews

I wanted to make the interview process a dialogue allowing women to describe in detail their life experiences. This for me was crucial in attempting to understand the processes that might lead to depression among second generation South Asian women and preferable to going through a long list of questions not allowing the replies to be put into the context of the women's life experiences. This stance flowed from the work of Brown and Harris and their studies on life events and depression over many years. Following their original Camberwell study on depression among women, Brown and Harris found that women encountering severe events in the face of vulnerability (in particular lack of a confiding relationship) were at risk of developing depression. The importance of life events, particularly with regard to depression has long been recognised (Pearlin, 1981; Brown and Harris, 1978). It was intended to focus on two key aspects in the interviews. These were life events and social support, both of which have been shown in numerous studies to be particularly implicated in depressive illness (Champion, 1992). In taking this stance I was particularly influenced by the Brown and Harris (1978) model of depression and by the work of Pearlin (1981). Although touched on briefly in the next section, both will be addressed in greater detail in the chapter on depression.

Measuring Life Events

Assessing the degree of stressfulness inherent in an event or set of circumstances includes interview methods such as those used by Brown and Harris (1978) which require that the researchers have a good deal of knowledge not only of the immediate context of the event but of the culture within which they are researching (Dohrenwend et al, 1977).

Most research into life events has been based on one of two distinct approaches: the 'checklist approach' associated with Holmes and Rahe and the 'investigator approach' associated with George Brown . The first and earliest stems from the work of Holmes and Rahe (1967) who developed a checklist of 43 life events "empirically derived from clinical experience". The common theme in all these events is that they either evoked or were associated with some adaptive or coping behaviour, the underlying assumption being that change, whether desirable, undesirable or both, is stressful. Holmes and Rahe (1967) used a random sample of adults to assign scores to the 43 life events reflecting the amount of adjustment they considered each event would require. A value given to marriage acted as the anchor in the scale. The weights so derived formed the basis of the Social Readjustment Rating Scale (SRRS). Later adapted as the Schedule of Recent Experiences (SRE), the checklist provides a self-rating scale, which can be used to quantify life changes.

Dohrenwend (1978) notes that the variability of judge's scores suggests the judges may be thinking of rather different types of occurrences when they are asked to assign magnitude scores to an event category such as 'divorce'. For Dohrenwend (1990), the problem applies to ratings of other important event characteristics such as their independence of personal behaviour and their desirability or undesirability. Lists of the Holmes and Rahe type do not allow for variability within life-event categories and thus equate, for example, all divorces whether they were precipitated by the behaviour of the respondent, or that of the spouse, or both; whether they arise precipitately and unexpectedly or whether they describe a relatively trivial incident coming at the end of a long separation that was far more severe in its early stages (Dohrenwend, 1990).

Wagner (1990) attempts to develop a framework for integrating the various approaches to life event measurement. He poses the question - 'Is it better to obtain subjective (i.e., subject as respondent) or relatively objective (either subject as informant or investigator based) indices of life event stress? Information about the context of the stresses may be important in interpreting the importance of the event. That is, if stressful events precipitate disorder for certain individuals, it may be necessary to learn more about the circumstances surrounding the event in order more fully to understand why the disorder occurred. The break-up of a marriage for example, is a relatively empty concept in and of itself. Did the respondent initiate the break-up or the partner? Was the break-up a long time in coming? For Wagner, the use of major event checklists, even in epidemiological studies, can never be more than a very rough variable, because of the lack of detail needed to bring the event to life.

Wagner (1990) believes it is important to ask 'What makes certain events stressful for certain types of people?'. To answer this question Wagner states the importance of measuring not only characteristics of the actual events but the person's experiences of these events. The 'objective' characteristics of the transaction, as best they can be determined, could serve as a marker against which variations in subjective appraisal could be understood in terms of multiple influences (personality factors, coping history, other ongoing interpersonal stresses, support systems, etc.).

Assuming that it is important to obtain a relatively objective assessment of stress, how should events be 'objectively' measured? The Holmes and Rahe method has been widely criticised, mainly because it ignores information, both experiential and contextual, regarding the transaction in question. A prominent critic of the Holmes and Rahe approach to life events and their measurement is George Brown (1974;1978) who believes some of the items on the list to be vague, and reliability and validity of reporting based on the checklist method weak.

Brown and Harris (1978) drew a distinction to the checklist approach as adopted by Holmes and Rahe when they developed the investigator-based approach to the measurement of life events, in which information is obtained through an interview and treated according to contextual threat. In advocating a more semi-structured approach to life event studies, Brown (1989) notes that most life

events research ignores the "*uniqueness of context*" by taking a dictionary approach to measurement. Consequently, when in an interview it is settled that an incident is to count as an event, it is essential to go on to cover, in as informal a way possible, details of what led up to and what followed it, and the full set of circumstances surrounding it. This is based on the feeling that the "check-list" approach fails to deal with the meaning of events for an individual. For instance, a planned first pregnancy in a couple with a secure personal and financial situation has a very different meaning from an unplanned pregnancy for a single parent with three children, living in an already cramped house and with financial problems, yet both would get the same score using a check-list system.

In their original 1978 study, Brown and Harris noted that "*a full account of past behaviour and circumstances surrounding an event will enable us to make, in the majority of instances, a reasonable estimate of the meaning of an event. Information about the context of the stresses is therefore important in interpreting the importance of the event*". This investigator-based approach to the measurement of life events, in which information is gathered through an interview and treated according to contextual importance, was to me the most effective way of proceeding with the study. This was based on the premise of wishing to gain an insight into the life experiences, hopes, goals, values and aspirations of the women as these factors are implicated in depression.

In taking this stance, I was strongly influenced by Brown (1978;1989) who posed the question, how far can an investigator, by taking account of context, make a judgement about likely meaning? Brown concluded that measurement needs to consider a person's values, plans, and goals in order to relate to what he calls "situation" and "meaning". Consequently, an assessment of meaning or understanding on the part of an investigator can and should take into account not just the present set of circumstances (such as a woman losing a job), but the wider context (the woman being unmarried, in debt with school children): that is, a more inclusive context of meaning (Brown, 1989). In their original 1978 study, Brown and Harris noted that a full account of past behaviour and circumstances surrounding an event will enable us to make, in the majority of instances, a reasonable estimate of the meaning of an event. Information about the context of the stresses is therefore important in interpreting the importance of the event. Thus, this approach is designed to investigate the likely

meaning of an event for an individual by assessing its place within his or her personal history and current situation, i.e., the *'person's biographically determined circumstances'* (Brown and Harris, 1978).

Brown and Harris (1978) and Brown (1989a) advocate a more semi-structured approach to interviews involving life events. Such an approach, they claim, is designed to investigate the likely meaning of an event for the individual by assessing its place within that person's personal history or current situation. It was with this approach in mind that the Bedford College Life Events and Difficulties Schedule was developed.

The Bedford College Life Events and Difficulties Schedule.

The Bedford College Life Events and Difficulties Schedule (LEDS), developed by George Brown, yields clear, standardised definitions for determining which events qualify for inclusion. Predetermined criteria for each type of event have been developed to ensure that only distinctive types of experiences are recorded as events. With LEDS, events are rated in terms of the focus of the experience (i.e., the person for whom the event is of primary significance). Based on the information gleaned during the interview, more individualised ratings of life stress can be performed with LEDS. For example, one feature is the development of contextual ratings for life stress (e.g. threat or unpleasantness associated with the event). This rating incorporates specific information concerning the life circumstances of the individual in developing the stress rating. That is, the rating attempts to address the degree of stress that may be associated with an event given the life context of the particular person involved. The ratings then are more sensitive to the likely meaning of the event for that person, yet are still anchored in externally verifiable circumstances. There exists an extensive catalogue of examples available to anchor these ratings, again in a standard format. Such procedures help to bridge the gap between the objective and subjective perspectives without resorting to the problems entailed with subjective perception (Brown and Harris, 1978).

The LEDS provides the basis for rating life events with respect to specific dimensions or characteristics. For example, some stressful events may be associated with experiences of loss (e.g.

deaths, separations), whereas others may be associated with danger of future adversities (e.g. serious illness). A variety of different dimensions may be part of the more global concept of stress and have distinct implications for subsequent functioning. In this vein Brown and Finley-Jones (1981) found that events of loss typically predicted cases of depressive disorders, whereas events of danger typically predicted cases of anxiety disorder. We know that much of what is referred to as life stress may not only be the result of temporally discrete life events but also of ongoing chronic adversities. Theoretically, this distinction is potentially important. Certain types of disorders with acute forms of onset may be associated with the occurrence of major life events (e.g., acute clinical depression). Other types of disorders may be related to more enduring forms of stress (e.g. cardiovascular disease). A comprehensive assessment system should be capable of addressing this aspect of stress also. The LEDS is designed to include ratings for ongoing difficulties of the subject's life. LEDS has been adapted by other researchers where research has taken place among specific populations , e.g., adolescents and the elderly. In a study of life events in an adolescent population, Monk and Dobbs (1985) modified the LEDS to take account of certain features specific to an adolescent sample. A similar adaptation was undertaken by Orrell and Davis (1994) in their study of life events in an elderly population. For my own study I used the LEDS approach but, as with Monk and Dobbs, in a modified form to take into account certain variables applicable to the South Asian community (see Appendix ? for Interview Schedule). As with Brown and Harris, I concentrated on key areas of a woman's life going from childhood to adolescence, school and education, employment, marriage, and parenthood. The women's social contacts, personal goals and aspirations were addressed. Issues specific to the South Asian community, e.g., racism, were also included as were probes on attitudes to religious and cultural traditions.

Before carrying out the 46 interviews, eight pilot interviews were completed. These helped shape the content of the semi-structured questionnaire. Although they covered areas I wanted to address directly, my approach was also flexible enough to allow the women the freedom to describe a range of life details and experiences.

As previously noted, it is believed that life events in and of themselves are not alone sufficient to lead to individuals, being at greater risk of depression. The importance of levels of social support has also been established. Given that social support, particularly the presence or absence of a confiding relationship, has been identified as a vulnerability factor in depression (Brown and Harris, 1978), it was important to investigate this factor in this study.

(2) Social Support: Its Measurement and Relevance to Depression

In attempting to specify the effect of social support on mental health, I will address two major issues: (1) Definitions and concepts- how should social support be defined and conceived; (2) Operationalization and measurement- what empirical measures should be designed as indicators of social support.

The concept of social support has been variously addressed in terms of social bonds (Henderson, 1980), social networks (Mueller, 1980), meaningful social contact (Cassel, 1976), availability of confidants (Brown et al, 1975; Miller & Ingham, 1976) and human companionship (Lynch, 1977). As Turner et al (1983) point out, whilst these concepts are hardly identical, they share a focus upon the significance of human relationships. It has been noted that there is little agreement about the concept of social support, and that the concept has been interpreted in several ways and includes a range of phenomena (Turner et al, 1983). As Ewalt (1960) has observed in relation to mental health, social support appears to mean many things to many people.

Despite this diversity of definitions, most focus upon the helping elements and processes of the social relation systems in which the individual is located (Gore, 1980). Thus Gottlieb (1981) refers to the substance of social support as "the help that helpers extend", and Lin et al (1979) define it as "support accessible to an individual through social ties to other individuals, groups and the larger community". In the same vein, Pearlin et al (1981) describe social support as "access to and use of individuals, groups or organisations in dealing with life's vicissitudes", and Johnson and Sarason (1979) refer to "the degree to which individuals have access to social resources, in the form of relationships, on

which they can rely". Cassel (1974) did not explicitly define social support, but he did point out that social support is provided by primary groups most important to the individual. This is consistent with the emphasis of Lin (1986) on the importance of binding relationships among confidant partners. House (1981) suggested that social support be examined in the context of "who gives what to whom regarding which problems?"

One area of concern in social support studies is that measures should not be confused with measurements assessing the mental well-being of the person being studied.

Dangers of Confounding Social Support with Mental Ill-health

As Donald and Ware (1984) point out, there is a potential problem in assessing social support in people with mental health problems as how people feel about their social support and their mental health can be intertwined. Subjective ratings of "being cared for" and "loved and wanted by others" are substantially related both conceptually and empirically to mental health. Measures of feeling loved and wanted, loneliness, and whether one's life is full and complete seem to have similar meaning (validity) as measures of anxiety, depression and psychological well-being (Viet & Ware, 1983). The conceptual confusion that can exist between mental health and the more qualitative aspects of social support has led some researchers to focus on more behavioural approaches to the measurement of social support. However, as noted previously it can be mistaken to rely completely on such behavioural constructs. Merely counting social contacts seems analogous to measuring mental health by counting the frequency of "feelings" without regard to whether they are good or bad. Despite these potential dangers Donald and Ware believe that personal evaluations of social circumstances are required for any definition of the quality of social support to be complete (Donald &Ware, 1984).

Whilst these points should be noted and are clearly very relevant, it does not automatically follow that because a person is depressed they will inevitably provide a clouded or incorrect view of their confiding relations. This line of thought implies that well individuals always provide an accurate reflection of their confiding relationships when in fact many people, for a variety of reasons including

a wish to disguise relationship problems, do not give an accurate reflection of confiding relations. The depressed person's condition may in fact result in their being more open and honest about their relations with people close to them or at least being more reflective. The emphasis on discussing close relationships retrospectively and prospectively in many of the services provided by the 'helping professions' for people with depression indicates the importance of assessing depressed individuals' assessment of confiding relations.

In a deeper analysis of this issue Turner et al (1983) states that this approach is consistent with W I Thomas's 1928 admonition that situations defined as real are real in their consequences. For Turner et al, it is an axiom of social psychology that events or circumstances in the real world affect the individual only to the extent and in the form in which they are perceived. As Ausubel (1958) has pointed out, " this does not imply that the perceived world *is* the real world but that perceptual reality is psychological reality and the actual variable that influences behaviour and development." Vega (1991) points out that Brown et al (1975) and Dean et al (1981) relate low perceived support directly to depression. In this respect Lowenthal and Haven (1981) and Lin (1986) cite the assessment of confidant ties as especially important.

My review of the literature in chapter 5 reports that there is no agreed definitive measurement of social support and before addressing the issue a number of theoretical and practical points need to considered. First, in any study the measurement of support must be guided by a theoretical conception of the nature of support and how support relates to other variables in the study, in my case depression. Both for conceptual and methodological reasons, it is useful to distinguish among different *sources* of support and among *types* of support. Which types and which sources are important depends on the nature of the problem under study (House & Khan,1985). Most conceptual and empirical analyses of support suggest that emotional support or affect should be distinguished from instrumental support or aid and that both of these should be distinguished from informational support and from affirmation or appraisal support.

This is demonstrated in House & Khan's belief that in spite of the afore-mentioned difficulty, this does not mean that the analysis of different types of support should be forsaken. Rather, theoretical analysis must be sharpened. Different types of support are most likely to be discriminable and to have different effects *as the nature of the problem requiring support varies.* Thus, those interested in measuring and demonstrating the empirical utility of different types of support must attend more to the problem-specific nature of the support process (House & Khan,1985).

For Turner et al (1983) social support refers to the clarity or certainty with which the individual experiences being loved, valued, and able to count on others should the need arise and conclude that the measurement of experienced social support (in this case confiding relations) must be a significant and indispensable part in assessing social support resources in mental health studies. House (1981) expresses the rationale for this approach when he states that social support is effective only to the extent perceived, and therefore that the subjective or perception-based measures are the most likely to demonstrate relationships with mental health.

Despite the rebuttal of the criticisms of assessing confiding relations in depressed individuals, it is worth noting that comparisons of depressed or mentally ill subjects with non-depressed or "well" people may help in assessing social support resources in mentally ill cases. As Bruhn and Philips (1984) point out, estimates of the parameters of social support used by well functioning people are necessary to provide comparisons for any assessment of the significance of social support networks used by people suffering the effects of major stresses and pathologies, such as depression and other mental illnesses. This approach was taken in this study where strength of confiding relationships was assessed in a non-depressed as well as a depressed group. This leads us on to how best to assess and measure social support in individuals.

The specific aspect of social support featuring in my study is confiding. The reason for this approach being that a measurement of confiding taps the dimension of social support that has the strongest relationship to depression (Brown & Harris, 1978; Pearlin et al, 1981; Schaeffer, 1981; Vega,1986). While a considerable debate now exists regarding the superiority of buffering/direct effect models of

social support, in terms of their amelioration of potentially negative health outcomes such as depressive illness, confidant support actually combines both models (Vega, 1986). Research findings from Pearlin's 1981 study suggest that confidant relationships have a strong main effect and also serve to buffer the impact of some stresses. Furthermore, Schaeffer et al (1981) found that the types of social support implicit in a confidant relationship are highly interrelated; in other words, caring, confiding, being reliable and boosting spirits occur concomitantly. According to House and Khan (1985), " Those who give us emotional support are the ones we also turn to for instrumental aid, information, and affirmation or appraisal." For these reasons, the measurement of confidant support provides an assessment of social support in my study. Other research on the mental health of South Asian women supports this decision. For example:

(i)Currer (1983), in her report on the mental health of Pathan women, drew attention to the relevance of Brown and Harris's (1978) work that highlighted the importance of confiding when she commented " *...the lack of a close relationship.....emerged as a significant social factor in relation to mental distress."* (Currer,1983; P.165);

(ii) Fenton's(1991) research on depression in South Asian women noted that one of the chief vulnerability factors in women becoming depressed was "*social isolation, including the absence of anyone to talk to on intimate terms.*"

(iii)Beliappa (1991) found that social isolation was a factor in mental distress of South Asian women. The research data suggested that a significant number of South Asian women did not view their immediate family as a durable support structure with a majority depending on themselves or community organisations for help.

I developed a tool to gauge support. This was heavily influenced by Brown and Harris (1978), Pearlin (1981) and Vega et al (1986) who considered a question on confiding a direct measure of expressive support tapping the existence of some form of intimate primary relationship both relatively pure and tapping the dimension of social support that has the strongest relationship to

depression. Furthermore, most complex measures of social support in use today also incorporate confidant support items or sub scales, permitting methodological and cross-cultural comparisons (Vega et al,1986). An example of this, and one which I drew heavily on in developing my own schedule, was Stansfeld's and Marmot's (1992) Close Persons Questionnaire (CPQ) whose central feature is a scale to assess confidant support. The question of social network was also addressed in order to assess the level and nature of out of the home activity of the women interviewed (See Appendix for details). The tool that was developed was done in such a way to gauge support and not as a definite quantitative measure of support.

Following a detailed analysis of studies involving social support and depression where confiding was the key social support component (Brown and Harris, 1978; Pearlin, 1981; Vega et al, 1986; Dean and Tausig, 1986), in my study women were asked

(a) Among your friends and family do you have anyone with whom you feel you can share your innermost thoughts, feelings and problems?

(b) If not - have you ever had anyone? If yes, what happened, why can't you confide in them now?

(b) If yes who are they, do you have more than one, name the others and your relationship to them (If they do not mention husband, probe, if not why not?)

(c) How often do you see the confidant/confidants?

(d) How do you feel about the frequency of seeing them?

(d) What does it mean to you to have these people, what issues do you discuss.?

This was seen as a generalised measurement and their replies were marked as follows:

Assessing Strength of Confiding Ties

'a'- Strong, one or more confidants available and seen at least once per week.

'b' - Moderate, one or more confidants available and seen approximately every month.

'c' - Weak, one or more confidants available and seen approximately every three months.

'd' Very weak, no confiding relationship.

Having established my approach to the interviews the next step was actually to organise them and carry them out. The next section explains how this was done.

Organising the Interviews : The Depressed Sample

Access to my depressed sample obviously had to be handled with a great deal of sensitivity. The individuals and groups agreeing to co-operate with me in gaining access to depressed women did not come to their decision lightly. Each individual and group representative interviewed me at least once, often rigorously, before deciding to co-operate with the research. An example of the procedure I had to go through was with a GP surgery in Glasgow whose health visitor, who had 15 years experience of working with South Asian women, had expressed an interest in co-operating with my work after I had spoken with her a number of times. The health visitor informed the surgery's practice manager who then arranged a meeting with one of the surgery's GPs. Following our meeting, the GP in question requested that I send a protocol of my study to the surgery for the other GPs to read and suggested that I attend their next surgery business meeting for a question and answer session on my research. This took place over lunch and lasted approximately one hour, whereupon they informed me that they would come to a decision in my absence and inform me by letter. The surgery then contacted me and informed me that they would be willing to co-operate with the research.

My approach to the psychiatric hospitals was fruitless in terms of obtaining people for interview. This was not unexpected, given the very low numbers of South Asian people who are cared for in psychiatric hospitals. Although interested in my study and willing to co-operate, the hospitals approached wrote back and informed me that they had no South Asian patients in their hospitals that met the criteria laid down for my sample. I wrote back and asked them to contact me if they were to take in any patients who would fall into my sample requirements. I did, however, take the opportunity to meet with a number of consultant psychiatrists to discuss issues related to my research.

My sample of depressed women came mainly on referral from GPs, and to a much lesser extent from mental health organisations working with South Asian women suffering from depression. The main concern of the GPs and health visitors who agreed to co-operate was that I approach the interviewees sensitively and respect and ensure total confidentiality.

This procedure raises some questions about my sample of depressed subjects. First of all, how reliable was the diagnosis as depressed? Secondly, does the fact that I interviewed depressed subjects put a question mark over the data, in the sense that by being depressed the interviewees' recall of events would be negatively biased? In addition, several studies have addressed the rival life event hypothesis that symptoms cause negative events and that both symptoms and events are caused by other person characteristics.

Possibility of Bias with Depressed Subjects

Following a review of studies in this area, Lakey and Heller (1985) report that there is little evidence that the event-symptom relation results from a reporting bias. Wagner (1990), in an article on research methods in depression studies, asked the same question and concluded that the results of a few studies which have attempted specifically to address this question have not been generally supportive of the hypothesis that depressed mood is associated with inflated reports of negative life events or higher ratings of the intensity of negative events (Cohen et al, 1988; Lakey et al, 1985; Siegal, 1979).

Lakey & Heller (1985), carried out an investigation into whether reporting biases could account for the correlation between negative life events and sub-clinical psychological symptoms such as depression by checking the accuracy of subjects' reports of negative life events by asking for confirmation by significant others, as used by Brown and Harris (1979). The hypothesis for their study was: If psychological distress affects reporting accuracy, then (a) significant others should be less likely to confirm the negative events reported by depressed subjects and (b) depressed subjects should be more likely to rate events as negative when significant others rate them as positive or neutral. Significant others were asked to report about life events experienced by the subjects. No evidence was found for a subject reporting bias associated with depression. In fact depression was significantly associated with a high rate of agreement between subjects and significant others as to which negative event occurred to subjects. This study suggests that response biases do not account for the relation between negative life events and depression and therefore that negative life events as reported by the subjects play a significant role in the development of their depressive illness.

In a similar study, Siegal et al (1979) assessed the influence of depressed mood state when responding to a life events questionnaire (Life Experience Survey: LES). The effect of mood state on both the number of events reported and the respondent's rating of the impact of specific events was examined. They found a lack relationship between mood state and responses to the LES. Again, this finding provides some indirect reason to suspect that life stress can lead to depression, rather than depression simply increasing the probability of reporting negative life events.

A further issue pertaining to my depressed sample is how representative they were of second generation South Asian women with depression. Another factor concerns the presence of a third person during the interview.

I believe that this study's sample was drawn from a reasonable representation of second generation South Asian women unfortunate enough to have depression, given the religious groups covered, the mixture from Edinburgh and Glasgow, and the age range interviewed. But what about those who did not agree to be interviewed? I only had reports of a few who fell into this category and the reason

given was that they were too ill to want to be interviewed. The question remains, did my sample represent those with the best relationships with the GP and/or health visitor? Were the women selected by the GP or health visitor according to some unspoken criteria? What about those who did not appear on the GP's list but who might be diagnosed as suffering from depression, why did they not appear on the GP's list? These are valid points that cannot be fully answered. I was in the hands of the GPs and health visitors. It would have been almost impossible to get sufficient numbers of depressed cases other than by relying on the good offices and co-operation of GPs and health visitors. The one point I stressed with the GPs and health visitors was that I only wanted those who came under my specified category and that the women had to be working skilled or semi-skilled, unemployed but non-professional category.

What about the presence of a third person during four of the interviews? Did this affect what was divulged by the women? The first point to state is that it would have been unlikely the interviews would have taken place were it not for the presence of the "third party". In the interviews where another woman was present, the three women (that is the third party, one of whom was present in two interviews) had been working with the interviewees for a considerable period of time and knew them well. Two of the interviews took place in the interviewee's home, another in the home of the "third party", another in a community centre. I was told that the interviewees in question were not so much concerned about being interviewed alone by myself but about what others might think if they were seen alone with myself. I have examined these interviews in detail. In the case of two they were very frank interviews with detailed personal experiences divulged. The remaining two interviews were of a similar nature to the other interviews I had conducted with women when I was the only other person present. I spoke with the "third persons" after the interview and they informed me that they had known the women in question for some time and that what interviewees told me they had known about already but that some of my questions had brought to light details they had not known. It was not a perfect situation to have another person present but, under the circumstances it was unavoidable. Having looked in detail at these interviews, I believe the data stand up along side the other interviews. The interviewees clearly trusted the "third parties", and felt they could speak

candidly in their presence. In my opinion it was better to do the interviews with the "third party" present, with the obvious potential drawbacks, than not be able to do the interviews at all.

Access to Non-Depressed Sample

This section of my sample was made up of women who used local family centres for child support, women who were users of local community services, women who participated in community education classes, and non-depressed women from GP surgeries. As with the depressed group a lengthy process of meetings and discussions took place to secure a representative access in sufficient numbers. This series of meetings was just as thorough as those gaining access to the depressed subjects. In arranging access to my non-depressed sample, a well known community project with a history of good working relations with the South Asian community in Pollockshields, Glasgow were initially reticent about co-operating and informed me that they very rarely worked with "academics" on research, despite frequent requests. It was only after two quite rigorous discussions with two of the project leaders, where one of them admitted afterwards that they had given me a "bit of a going over", that they agreed to co-operate.

Similar questions about representativeness arise with the comparison group. Did I get access to those South Asian women most convenient for the gatekeepers to contact and were these women who were more prepared to meet with and be interviewed by a white male? Again, this is difficult to answer. The gatekeepers may have listed the most obvious women who would have no difficulties meeting and being interviewed by me. On a number of occasions, however, I did have to stress that I did not want to interview "committee people", i.e. local activists. I wanted users of services. I do not know with this section of my sample how many women approached refused to participate. The response from the bodies giving me access was very positive.

Having decided on my approach to the study, finally the question of the reliability of my sample should now be addressed. As previously stated, I decided that a comparative study with second generation South Asian women with no current or past history of depression would be the best as it would show that, as with white indigenous women, there is a wide divergence of life experience in

the South Asian community and that whereas some people suffered from social problems which caused mental health difficulties others did not or else coped with such difficulties in a number of different ways. One question which has to be addressed is the reliability of both categories, were the depressed actually depressed and the non-depressed actually not suffering from depression.

Reliability of Depressed and Non-Depressed Categories

My decision to do a comparative study with non-depressed South Asian women raised the question of whether I could be certain that women in the comparative group were not themselves suffering from depression. The question also arose as to whether the women referred to me with depression did in fact have a depressive illness: doctors have been known to get their diagnoses wrong. I decided to use a depression scale to check for the presence or absence of depression. The choice of scale was given significant consideration, particularly in the light of debates over the validity of western psychiatric approaches to non-western populations, which I shall now look into.

Cross-Cultural Mental Health Studies

The growth of cross-cultural research in psychology and psychiatry over the last two decades has brought attention to bear on two important points: firstly, that rates of psychiatric morbidity are usually similar in Western and non-Western countries; and secondly, that there are differences in clinical presentation of various illnesses in different cultures (German, 1987; London, 1988).

Cross-cultural research in symptomatology, case definition and nosology of psychiatric disorders has long been interpreted in either of two main ways. One is the culture-general (etic) approach, which sees psychopathology as universal disease phenomena while sociocultural influences are mainly pathoplastic. The other is the culture-specific (emic) approach, which emphasises differences in psychopathology between different cultures (Murphy,1982). In a review of studies from 40 countries King (1978) concluded that psychopathology is universal but that its signs and symptoms differ from culture to culture. In a similar vein Kinzie and Manson (1987), following their review of seven psychiatric self-rating scales used in cross-cultural research on depression, suggested that certain

biological symptoms of depression may be universal but that psychological symptoms tend to be culturally rooted.

Anthropologically oriented research workers like Kleinman (1987) have stressed the difference in illness behaviour among different cultures and its influences on symptoms, patterns of help seeking, course, and treatment responses. He has also pointed out the inadequacy of applying a diagnostic category developed for one particular culture to members of another culture without proper consideration of its validity for the latter (Kleinman, 1977). In the 1970's the remedy for the bewildering multiplicity of diagnostic symptoms appeared to be the use of structured interviews, such as the Present State Examination, to ascertain the basic phenomena of psychiatric pathology. This approach, however, came under heavy criticism from the advocates of the 'new cross-cultural psychiatry' for imposing Western concepts of psychopathology on non-Western peoples. Kleinman (1977) pointed out the inadequacy of applying a diagnostic category developed for one particular culture to members of another culture without proper consideration of its validity for the latter. It has been suggested that culturally specific signs and symptoms of a ubiquitous disorder, such as depression, will be overlooked if one uses only diagnostic criteria from a Western culture in a non-Western setting (Fabrega, 1974; Kleinman, 1977). The particular point of Western diagnostic criteria being used in a non-Western setting, according to some cross-cultural psychiatrists, can result in depressive illnesses not being diagnosed among some ethnic groups such as the South Asian community and could be one of the reasons for the relatively small numbers of reported cases of depression within the South Asian community in Britain.

It has often been asserted that patients from developing countries 'somatise' their depression, whereas patients in the Western world 'psychologise' depression (Leff, 1982). Kleinman (1987) refers to the "widespread finding" that "somatic symptoms in depression and anxiety disorders play a more central role in the experience and expression of disorder in non-Western societies and among ethnic groups in the West". However, as Mumford et al (1991) points out, it is not known whether such symptoms are generally *experienced* more often by patients in non-Western societies than among patients in the Western world. No one, claim Mumford et al, is aware of any multicultural

study that has set out specifically to compare the prevalence of somatic symptoms in different ethnic groups using a comprehensive inventory of such symptoms. It is also worth noting briefly that indigenous white British patients who present to doctors complaining of depression or anxiety also describe a variety of somatic symptoms (Hamilton,1989). In addition, many indigenous white British patients attend their GP. or hospital out-patient clinic with somatic symptoms for which no physical cause is found (Katon et al, 1984; Goldberg & Bridges, 1988).

In relation to South Asians in Britain, patients of Indian and Pakistani origin suffering from anxiety or depressive disorders frequently present to the doctor in Britain with somatic complaints (Rack,1982; Bavington & Majid,1986; Bal,1987). Difficulties with the English language may prevent a clear history of mood change being elicited. However, when questioned in their own language, and/or with culturally appropriate terms, such patients are usually able to describe the psychological symptoms of a mood disturbance (Bavington & Majid,1986; Rao,1986; Krause1989).

Although Kleinman's concerns may be relevant in the case of first generation South Asians socialised in the varied social and cultural environments of their own countries before migrating in the 1960's, the question is whether this applies to my sample which contained second generation South Asian women born in Britain or who arrived before the age of 5 years, and who were educated and socialised in this country. The research that has been conducted on depression in South Asian women in Britain suggests that second generation South Asian women perceive and experience depression in very similar ways to indigenous white women. In their study on depression among South Asian women in Bristol, Fenton and Sadiq (1993), found that the South Asian women experienced characteristic clusters of thoughts and feelings which were very much akin to what English speakers describe as depression (most of the women were born in Pakistan); the women viewed this disorder of thought and feeling as illness (*bemaari)* and as an illness of the mind (*soochne ke bemaari);* they perceived and described their problem as profound sadness which had become an illness; the South Asian women clearly perceived the connection between "psyche and soma", the multiple ways in which physical and psychological problems interact (Fenton & Sadiq, 1993).

Similarities, therefore, have been shown to exist in the presentation of depression among South Asian and white patients. Furthermore, a study by Howlett et al (1992) into South Asian, white and Afro-Caribbean peoples' concepts of health and illness causation found that Asians gave similar responses to the other two groups to the notion that worry, stress, and tension were the causes of depression (54% South Asian, 51% white, 58% Afro-Caribbean). Other studies have also reported that Asians acknowledge worry and stress to be significant factors in both physical and mental illness (Donovan, 1986). These studies appear to back up the World Health Organisation (WHO) findings of 1983 which suggested that the core symptoms of depression are similar in different cultures.

It is 50 years since Sapir asserted that human beings speaking different languages do not live in the same real world with different labels attached;but live in different worlds, language itself acting as a filter on reality, moulding their perceptions of the universe around them (Werner & Cambell,1970; Edgerton & Karno,1971). If this hypothesis is taken literally, translation from one language to another is impossible. Critics have cast doubt on the whole process of translating psychological concepts into a different cultural setting, arguing that questionnaires and tests must be created anew in each culture (Lutz,1985; Obeyesekere,1985). It seems a justifiable to argue that a failure to ensure the cultural congruence of individual items is likely to lead to serious problems with concept validity when they are used as components of a psychological instrument as many in the field of cross-cultural research argue. There is no denying the difficulties. Particular problems can be anticipated with terms that describe subjective emotional states, for which nuances of phrase are very hard to convey in a different language. But, are we dealing here with an all or nothing issue? Must these scales be created anew in each culture?

Conscious of some of the anthropological criticisms, Mumford (1991) set about developing a scale for use in depression studies involving the South Asian community, through the development of the Bradford Somatic Inventory (BSI). The results of the factor analysis of the BSI revealed both similarities and differences between functional patients in Britain and Pakistan. Four principle clusters of symptoms emerged in both ethnic groups: head, chest, abdomen and fatigue. The four

other factors in the eight-factor solutions were somewhat similar between the two groups. Of the four principle factors, three relate to zones of the body(head, chest and abdomen). The fatigue factor was also remarkably consistent, with five items in common between the two ethnic groups. This factor contains the core somatic symptoms of 'fatigue syndrome', with tiredness, lack of energy, and muscular pain and weakness (Wessely, 1990).

Mumford et al drew three major conclusions from these factor analyses. Firstly, most of the clusters of somatic symptoms show obvious similarities across the cultural divide. They state that this would seem to suggest that the core somatic experiences, which these dimensions of functional somatic experiences represent, are universal human experiences, largely independent of culture. The authors go so far as to state *"these results certainly offer no support for the extreme position of cultural relativity espoused by some anthropologists"*. (They cite Littlewood,{1990} as an example).

Following an analysis of a range of depression scales in particular, the Hospital Anxiety Depression Scale (HADS), the Bradford Somatic Inventory (BSI), the Langer 22 Item Scale and the General Health Questionnaire (GHQ), after much consideration and discussion I decided on using the Hospital Anxiety Depression Scale HADS scale.

Hospital Anxiety Depression Scale (HADS)

The HADS was developed to screen for clinically significant anxiety and depression in patients attending general medical clinics. It comprises an anxiety and depression sub-scale: each sub-scale consists of 7 items and each item has a 4-choice response format.

Nayani (1989) carried out a study to determine the usefulness of the HADS self-assessment scale in South Asian patients and also to study the expression of various psychological and somatic symptoms. South Asian patients suffering from neurotic illness completed the HAD scale which had been translated into Urdu. The results were compared with the Clinical Interview Schedule (CIS; Goldberg et al 1970) which was not formally translated. In order to evaluate the usefulness of the HAD as a screening instrument for South Asian patients, the anxiety and depression sub-scales of the

HAD were compared with the CIS anxiety and depression ratings. In the case of the HAD anxiety sub-scale, specificity was low at 37.5% ; sensitivity was 66%. The HAD depression sub-scale had a specificity of 70% and a sensitivity of 85%. When the anxiety and depression sub-scales of the HAD were correlated with the CIS anxiety and depression ratings, the sensitivity and the specificity of the depression sub-scale was satisfactory but the anxiety sub-scale had a low specificity. Nayani (1989) postulates that this could be because somatic symptoms, which he believes could be a manifestation of anxiety, were rated separately from anxiety symptoms in the CIS but the HAD no such facility. Therefore, all anxiety symptoms (which may include somatic symptoms) were rated under a common heading of anxiety in the HAD. Thus the translated version of the HAD scale failed to identify patients with anxiety (based on CIS assessment).

An important part of Nayani's study was the translation of HAD scale for use with Urdu speaking patients. The HAD scale was translated using the back-translation method, described as the best method by Werner & Cambell (1970). In defending this method Nayani cited successful use in Africa of the translated version of the Present State Examination (PSE) by Orley & Wing (1979), the translation of the PSE into seven languages and used in the International Pilot Study of Schizophrenia (WHO,1973), and the use of the translated version of DSM-III in Botswana by Ben-Tovin (1985). In these particular cases, the authors emphasised the importance of the translation of the concept rather than the literal translation of sentences.

According to Nayani, this study demonstrated that it was possible to detect depressive illness in South Asian patients with the help of a translated version of a self-rating scale. The Urdu version of the HAD scale, states Nayani, is designed in such a way that it could be used by a non-Urdu speaking clinician to detect psychiatric and in particular depressive illness in Urdu speaking patients. The scale was acceptable to the patients and the majority had no difficulty in completing it (there would of course be a difficulty with illiterate patients). Nayani also adds a cautionary note, that in its present form the translated version of the HAD scale has a limited role as a screening instrument for anxiety and, therefore, is not recommended as a diagnostic device.

The use of the HAD scale on South Asian populations is not without its critics, however, when used as a self-rating instrument in diagnosing depression in Asians. Chaturvedi (1990) believes that the HAD scale is an inappropriate method when used on South Asian patients, claiming that a number of items in the HADS are not reported by Asians, at least in the form in which they have been presented in the scale. Similarly, states Chaturvedi, there are a number of items which are reported by depressed South Asian patients which are obviously not contained in the HADS but would be of more discriminatory value. For Chaturvedi the poor correlation between somatic symptoms and HADS depression is quite expected, since, according to him, the items may not be measuring depression. Studying correlation between somatic symptoms and another measure of depression standardised for South Asian subjects would confirm this. Chaturvedi states that Nayani's study is an example of cross-cultural psychiatric research ignoring issues of cultural and conceptual validity.

Replying to this criticism, Nayani (1990) states that the myth of depression in South Asian patients is not valid any more and points to the WHO (1983) study as one of many which suggest that the core symptoms of depression are similar in different cultures. For Nayani, with appropriate examination, one can elicit psychological symptoms of mood disorder in patients from South Asian or any other culture.

Mumford (1990) regards Chaturvedi's criticisms of Nayani's study and the use of the HAD scale as too sweeping and defends the use of HADS among South Asian patients by drawing attention to his work with HADS and South Asians. Together with colleagues in Pakistan, Mumford completed an evaluation of a new translation of the HAD scale in Urdu. A five stage process was used; (a) initial drafting in Urdu by six independent translators; (b) translations back into English and modification of the Urdu version; (c) evaluation of linguistic equivalence of items in a large bilingual population; (d) evaluation of conceptual equivalence by examining item-sub-scale correlation's; and (e) evaluation of scale equivalence by two way classification of high and low scorers. Mumford (1990) states that the results obtained in their study do not justify the scepticism of Chaturvedi. In a more detailed analysis of this particular study, Mumford (1991) comments further on HADS suitability for use among South Asian patients.

In terms of linguistic equivalence, the mean anxiety score on the Urdu version of HADS was 7.66, and on the English version 7.25 (difference = 0.41, 95% confidence interval -0.02 to 0.84, NS). The mean depression score on the Urdu version of HADS was 4.65, and on the English version, 4.64 (NS). In terms of scale equivalence, the method used to evaluate scale equivalence was to determine whether the Urdu and English versions of the HADS identified the same individuals as high scorers. A two way classification of high and low scorers was constructed using the cut-off points below which a clinically significant syndrome of anxiety or depression is unlikely (7/8) and above which a clinically significant syndrome is probable (10/11). A high concordance rate indicates a high degree of equivalence between the Urdu and English versions of the HADS. The results indicated that quite high concordance rates were achieved. Mumford et al conclude that their demonstration of satisfactory linguistic equivalence, conceptual equivalence and scale equivalence of this new Urdu translation of the HADS suggests that it will be a useful measure of anxiety and depression in Pakistan.

I decided on using the Hospital Anxiety Depression Scale (HADS), principally for three reasons. Firstly, the HADS scale has been used in studies among South Asian people both in Britain and Pakistan and has been found to be reliable and valid (Mumford, 1990; 1991). Secondly, I had received reports on its suitability as a reliable instrument from two South Asian doctors in Glasgow, one a GP and the other a consultant psychiatrist, who had used HADS with their South Asian patients. Thirdly, I wanted to use a scale that would be quick and easy to administer and the HADS scale suited that purpose. In my study the HADS scale proved to be a suitable instrument, confirming depression in the depressed sample and, according to the diagnostic criteria of the scale, uncovering one case in my comparative sample. The woman in question was not included in the non-depressed category and was transferred into the depressed group. It later emerged that the woman in question began receiving treatment for her condition after my interview with her had been completed.

The next step in this lengthy process was actually carrying out the interviews themselves.

The Interview Process

In organising interviews with the depressed subjects, the active co-operation of a third party "gatekeeper" was essential. The "gatekeepers" were GPs and/or health visitors who had a working relationship with depressed South Asian women who came under my requested categorisation. The GP and/or health visitor drew up a list of women who would be eligible for inclusion in my sample on the grounds that they had been diagnosed as depressed by a GP or psychiatrist and were currently receiving treatment for their condition. They then discussed, over a period of weeks, my research with the women and ask if they would be interested in being interviewed. If the woman expressed an interest a joint letter would be drawn up on behalf of myself and the GP or health visitor explaining my research and what was entailed if the woman agreed to be interviewed. It was stressed that the women could be interviewed in the home or GP surgery or anywhere else they felt comfortable and that they could withdraw from the interview at any time. I also explained they could choose to be interviewed on their own or with the health visitor present. The question of confidentiality was stressed. I would then await a reply to the letter and on receiving a positive response speak with the woman over the phone and arrange a date, time and venue for the interview. A total of 9 interviews with depressed subjects took place in their homes, 12 took place in GPs' surgeries and 2 in community centres. Four out of the 23 depressed subjects were interviewed with another person present; on two occasions a health visitor was present; one occasion a social worker; and on another occasion a community mental health project worker. The average length of interview was 1 hour and 45 minutes, the longest being 3 1/2 hours. In those cases where I felt a re-interview may have been necessary or beneficial an overwhelming majority agreed to be re-interviewed. A total of 8 people were interviewed a second time. Fifteen out of the 22 interviews in the non-depressed sample took place in rooms in community/family centres. The remainder took place in the interviewees homes. As with the depressed sample, the gatekeepers were well known to the women and there existed a strong element of trust and respect between them. Being given the go-ahead by the gatekeepers clearly facilitated the interview process by this fact.

Information Gathering and Analysis

It was intended to use a tape recorder to record each interview but on asking the women during the initial interviews none were happy about the interview being tape recorded. The women when asked were uneasy about being recorded. This was because of the fact that the women spoke quite frankly about their experiences and felt that the tape recording might compromise their confidentiality. There was no other option but to take notes. Copious notes were taken throughout interviews. I felt initially that taking notes was not the ideal way but grew adept at getting down all the information during the interview process. Analysis of the interview data was done on computer. Initially each interview was typed into the computer and full transcripts were looked at and discussed. As the number of interviews increased, the interviews were broken down into emergent themes and the emergent themes discussed. Once all the interviews were completed the emergent themes were identified, gathered together analysed and then cross-analysed. A number of themes emerged: divergent attitudes to maintaining religious and cultural traditions, the nature of life events in both groups, the levels of confiding support in both groups, and the impact of racism on the lives of the interviewees. The emergent themes were then analysed in detail and the meaning and importance of the themes considered against the backdrop of existing literature and the researcher's own views.

Interviewing the Women

A great deal of existing research on depression and mental health problems in South Asian women has focused attention on "culture conflict" (e.g. Merrill, 1989;1990). Cultural experiences obviously play a major part in our lives but I was concerned that the "culture" label was being used too loosely to cover a multitude of social processes which could, in fact, apply to indigenous white women as well. Using the all encompassing term "culture conflict", I believe, prevents a detailed analysis and understanding of differences between South Asian and white indigenous communities, as well as similarities. If, as studies such as Merrill's (1989;1990) suggest, culture and tradition were factors, or if Ahmad (1993) was correct in saying racism was they key issue I wanted the women to bring these issues out themselves, rather than me attempting to relate it to "cultural" or "racism" issues.

Drawing on Brown and Harris, I wanted to investigate the likely meaning of events for an individual by assessing their place in the 'person's biographically determined circumstances'. To achieve this I deemed it necessary to gain an insight into the women's social and personal environments as perceived, defined and described by themselves. Consequently, I developed a semi-structured interview schedule designed to cover specific areas relating to educational experiences, employment, marriage, parenthood, social contacts, aspirations, personal goals. Eight pilot interviews were completed which helped shape the content of the semi-structured questionnaire. Although these were areas I wanted to directly address, the interviews were also flexible enough to allow the women the freedom to describe a range of life details and experiences. A copy of my interview schedule is included as appendix? Six main themes emerged from the interviews: family upbringing, education experiences, career ambitions, marriage experiences, parenting experiences.

With every interview I explained what the research was, why I was doing it, and that everything said would strictly be between the woman interviewed and myself. I explained that I would be writing about what was said in the interview but that no names would be used and there would be no way of identifying the women interviewed. In approaching the interviews I was conscious of the need to put the women at ease. On meeting the women we talked of general issues not related to the research. This could last 5 or 25 minutes. I would lead gently into the research, although in fact on many occasions the "small talk" often led directly into some of the areas covered in the interview schedule. With many of the depressed women the interviews were very lengthy, for some it was an opportunity to discuss issues they felt very strongly about. I had the impression from a number of women that they very rarely had the opportunity to discuss some of the issues they raised and in the manner they spoke about them. As stated previously I asked the women to tell me about themselves. Growing up in Scotland, school, educational and employment intentions, marriage, parenthood. I would ask them to explain further specific points for example if they said "I had to leave school" I asked them to expand, explain why, how they felt about this. If they stated 'its a cultural or traditional thing' I asked then what they meant, what is 'the culture' and/or 'the tradition' what were their views about it, why they agreed or disagreed etc.

In addition to interviewing women individually I carried out two focus group interviews, both of which had 6 women present. In one of these meetings I showed a video of a debate on the South Asian family, part of a Channel 4 series of programmes called "The Devil's Advocate". The programme featured a cross- section of the South Asian community. After the programme a, sometimes heated, discussion took place on some of the issues raised in the programme which lasted an hour and a half. In the other group meeting, which also had 6 people present, we had a general discussion about the South Asian community and what it meant to be an South Asian woman in Scotland. Again the discussion was very candid and elicited a range of interesting, often humorous, comments. The comments in these meetings were along the same lines as those in the individual interviews and it demonstrated, again as with the individual interviews, that the women hold a range of contrasting opinions. These came out sometimes angrily during the focus groups. Interestingly one of the focus groups had a debate on the question of racism with some saying it wasn't as big an issue as was made pout and others saying it was important. There were differing viewpoints on other ethnic minorities and white Scottish people. I took this opportunity to ask them, as I had done in a number of the one to one interviews how they felt about being interviewed by someone like myself who not from their community and who they had only just met.

The Outsider in the Interview Setting

A number of women stated that because I had worked with the health visitor or GP or counsellor, who they had complete trust in, and who helped set up the interviews, they felt their confidentiality would be respected and that the interview would not be a daunting experience. It is interesting to note here that in the one to one interviews some women stated that they would not have participated had I been from the South Asian community and that because I was an 'outsider' so to speak, they were confident that what was said during the interview would remain between myself and them.

The question of 'outsiders' carrying out interviews with South asian people a contentious one. When, speaking at a conference in Scotland on race and research, I noted that some of the women were happier with an outsider because of the issue of confidentiality, I was roundly attacked by one delegate from London. The woman stated quite categorically that I was advocating that South Asian

health professionals are incapable of working in and with their own community. I was, of course, suggesting no such thing and pointed out that were it not for the excellent work and active co-operation of South Asian health and welfare professionals and volunteers my study would not have been possible. One cannot dismiss the fact that some South Asian women, probably a small minority will not go to South Asian mental health workers if in some way they know that person for fear of her troubles being known. There would be little or no chance of this of course as these professionals would treat such an interaction in the strictest confidence. Some people, however, may fear the worst and keep their own counsel. No matter how groundless, the fear of some people finding out about their personal problems is enough to make some people reluctant to see counsellors from their own community. Three or four women actually stated this to me during our interviewees.

Concluding Comments

After considering the methodological and practical issues arising from this study, a few concluding comments would be useful. Ethnographic research of this nature can be problematic and/or flawed unless the researcher/s involved in the study are aware of and understand 'race' and gender issues both in society generally and in the interview process itself. In this chapter I contend that imperfections in data gathering, particularly in relation to the interviewers part in the process, must be discussed. However, in the interpretation of research findings, researchers must be more prepared to recognise their complexity and avoid the dangers of reductionism that can arise out of single factor explanations.

With respect to the development of measurement tools to gauge the level of life events and social support and the presence of depression, a great deal of time and thought was given to this. The researcher recognises the validity of anthropologically oriented researchers who note that the difference in illness behaviour exists among different cultures and that this can effect patterns of help seeking and responses. However, the sample in this study were either born in this country or socialised in it from the age of 5 years onwards. Their illness behaviour, patterns of help seeking and responses were very similar in nature to those found in white indigenous women. Other, larger, studies have also found this.

The assistance of individuals and groups in actually being able to carry out the research was of critical importance. Throughout the fieldwork the researcher continually stressed that the women had to fall into the selected categories explained earlier as well as being representative of 'ordinary' second generation South Asian women, and not community organisers or activists.

The interview process was significantly assisted by the researcher developing an understanding and working relationship with GPs, health, social and community workers. The interviewee's trust in these individuals and my commitment to guarantee complete confidentiality was also of crucial importance. The interviews, as one would expect, revealed a range of contrasting views and experiences, out of which a number of themes were found to exist.

Chapter 4

Section1: Stress, Life Events, Social Roles and Depression.

Section 2: Data Analysis.

Section1

Introduction

The relationship of stressful life events to the aetiology, onset, course and outcome of various psychiatric conditions, such as schizophrenia, depression and anxiety, has been the focus of a great deal of empirical research. The results indicate that the degree of causal significance between stressful life events and illness varies with the nature of the disorder, as does the role of stressful life events in the disorder (Brown, 1978; Leff, 1980). Research into the role of life events in the onset of depression among women has suggested that certain life events (severe events or major difficulties termed *provoking agents* by Brown and Harris) can increase the risk of a depressive disorder in the face of vulnerability factors (Brown and Harris, 1978). The link between stressful life events and mental ill-health is a corner stone of the social psychological and sociological approach to mental illness. Social predictors of depression have been identified in a number of studies, two of the most notable being Brown and Harris (1978) and Pearlin (1981) where stress and life events has been identified as major contributory factors in the onset of depression in women. There are two sections in this chapter. In section one I shall address the major discussions relating to the concepts of stress, life events and their part in the development of depression. In doing so I shall draw heavily on the work of Brown and Harris and Pearlin, both of which have identified the importance of social roles in the aetiology of depression. I shall also investigate the concept of social roles and the approach I believe most effectively addresses this concept. Finally I shall explain how stressful life events, particularly the concepts of loss and conflict over social roles, are key variables in the aetiology of depression in women.

Section two will deal with data analysis where I shall use my own interview material to demonstrate that social roles play a consequential part in life events (in particular where conflict or strain exists over the roles performed or sought out) among second-generation South Asian women. Furthermore I shall show, as with Brown and Harris' studies, that the concept of loss is an important variable in the make up of severe events in second-generation South Asian women, as are the variables 'severe events without loss' and 'major difficulties'. It will emerge from this section that all these factors played an aetiological part in the onset of depression among second-generation South Asian women who participated in this study.

Stress

The term stress is used by some to refer to an external environmental force and by others as an internal state of psychological or physiological tension. Definitional problems regarding stress are long standing and complaints about the misuse of the term "stress" are common. Despite considerable effort and debate, no uniformity of opinion has emerged on its definition (Monroe and Roberts, 1990).

Lazarus and Folkman believe that stress is an on-going process, implying that change is ever-present. They also emphasise that stress is in the eye of the beholder. A widely cited definition of stress is that of Lazarus and Folkman (1984): "*Psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being*" (1984:19). The concept of stress as 'social re-adjustment' was advanced by Holmes and Rahe and was defined as the "*intensity and length of time necessary to accommodate a life event, regardless of the desirability of this event*" (Holmes and Rahe, 1967:213). There are sharp differences between the two aforementioned definitions of stress. Lazarus and Folkman's definition of stress arose out of a model concerned with understanding adaptation to all stresses, including those of every day living, the so-called 'garden variety'. Holmes and Rahe advance the notion that stress is equivalent to change, presumably against a background of equilibrium or no change. Thus, the implicit goal of the individual within this model is to find a solution to the existing problem (Holmes and Rahe, 1967).

Cox and Ferguson (1991) identify three approaches to the study of stress: the stimulus based or engineering approach; the response based or medico-physiological approach; and the more psychological approach exemplified by 'interactional' and 'appraisal' theories of stress (Cox and Ferguson, 1991: 7).

The engineering approach sees stress as a stimulus characteristic of the person's surroundings, commonly cast in terms of the load or level of demands placed on a person or some adverse or noxious element of that environment. On the basis of this approach, stress produces a strain reaction.

The medico-physiological approach sees stress as a generalised and non-specific response to adverse stimuli. This approach stems from the work of Hans Seyle, and contends that stressors give rise, among other things, to a stress response.

Although popular, these approaches have been seen as inadequate both in terms of their ability to account for the available data and in terms of their theoretical refinement. These criticisms flow from their failure to take account of the individual differences which are so obvious in relation to stress, and the 'perceptual and cognitive processes which underlie such differences' (Cox and Ferguson, 1991:7).

Cox (1987) emphasises the psychological nature of stress, and favours the appraisal model of stress. Appraisal models regard stress as a psychological state which is the internal representation of a specific and difficult interaction between the person and the environment. Appraisal is said to consist of primary and secondary processes. For Cox (1987), primary appraisal is comparable with the stressful characteristics of situations. Secondary appraisal is linked to the question 'what, if anything, can be done to resolve them'. Consequently, it is a decision-making process which should take account of the coping resources and options available to the person, their preferred styles of coping and the nature of the stressful situation (Cox, 1987: 9).

Cox and Ferguson (1991) contend that four things are significant in the process of primary appraisal which are linked to both situational and personal factors. These are - the external and internal demands that the person experiences, matched against their personal coping ability and resources, the control they have over coping, and the support they receive from others in coping.

This raises the question of individual differences in the appraisal of a stressful event. For Wagner (1990), if stressful events precipitate disorder for certain individuals, it may be necessary to learn more about the circumstances surrounding the event in order more fully to understand why the disorder occurred. It is, therefore, important also to ask 'What makes certain events stressful for certain types of people?' To answer this question, it is important to measure not only characteristics

of the actual events but the person's experiences of these events. Cox and Ferguson (1991) note that primary appraisal is, by its very nature, subject to mediation by individual differences: firstly, in that individual differences can occur in relation to each person's perception of job demands and pressures; secondly, in that people vary in their capability to cope with demands, and their perceptions of those abilities; thirdly, in that people may vary in the level of control they can exert over any situation, not only as a function of that situation but also as a function of their beliefs about control. Finally, people may differ in their need for social support and their perceptions of support.

Social Roles and Stress

Following their studies, Kessler et al (1985), found that women were more likely to experience particular stresses than men and related this to the roles that women occupy in our society. Kaplan (1990), argues that the work of Kessler is important in that it highlights the importance of social roles in life events measurement. In the same vein, Thoits (1987), suggests life event measurement strategies should involve social roles. Thoits' research indicates that stresses unique to specific social roles (e.g. those experienced by married women) are more strongly related to psychological distress than common stresses that are experienced by all individuals regardless of the roles they occupy. Furthermore, Thoits argues that the crucial harmful feature of life stress may be found by concentrating on those events that arise in the roles that are most important to study participants. For Kaplan (1990), Thoits' research findings suggest it is possible that the assessment of stresses may be confined to events associated with a more limited range of unique roles. Kaplan concludes that "*there appears to be a promising theoretical rationale for hypothesising that stresses arising from salient social roles will have an especially deleterious effect on health and psychological well-being*" (Kaplan, 1990:206). In addition, he goes on to note that the effects of stresses arising within salient social roles should also be assessed in conjunction with selected social resources.

According to Pearlin (1981) the occurrence of a stressful event is determined by the environment that demands changes to the individual. When change occurs it creates disequilibrium, that in turn imposes re-adjustments that can be wearing and exhausting. Conceptually, Pearlin (1981) refers to stress as continuous or on-going circumstances, rather than discrete isolated events which are

commonly regarded as undesirable or problematic. He identified as a source of stress, eventful experiences (critical life events that directly impact upon people) and life strains (persistent life problems) and their relationship to self-concept and the stress outcome Pearlin most commonly uncovered was depression (Pearlin, 1981; 1983; 1989).

Pearlin (1983) believes that the changed circumstances of roles with which people have to cope in their everyday lives are in fact highly related to stressful experiences. In an interesting follow-on from Brown and Harris's criticisms of some aspects of life events research, Pearlin (1983), contends that the fact life events can exert their effects directly through their influence on roles does not mean that we should not pay considerable attention to events. What it means, however, is that when life events are considered as antecedents of stress, we might profitably do so in conjunction with a consideration of roles. Focusing on roles as a source of stress, should bring the part played by life events in the stress process into, what Pearlin calls, a "more balanced and interesting perspective" (Pearlin, 1983).

The lack of agreement on a definition of stress can lead to empirical difficulties. Brown and Harris (1978) contend that taking self-reports of stress leaves the job of its assessment with the subject instead of with the investigator. Consequently, their assessments of whether a situation or event is stressful is dependent on the context of the situation and the meaning of such an event in the individual's life.

On the basis of the above review what can be deduced as regards the content and influence of stress? Broadly speaking, stress is the occurrence of the disruption of meanings, understanding and regular functioning. The ability to deal with this experience depends on a person's coping mechanisms, particularly support from others. Stressful life events do not spring out of a vacuum but can be traced back to surrounding social structures and people's location within them. Furthermore, interrelated levels of social structure- social stratification, social institutions, interpersonal relationships- shape and structure the experiences of individuals and some of these experiences can turn out to be stressful. Consequently, the structural contexts of people's lives are not extraneous to

the stress process but are fundamental to that process. In addition, as Cox notes, this position draws attention to the importance of social context, and (as already noted in chapter 3) is something George Brown has stated as being of crucial importance in understanding and assessing the content and impact of stressful life events.

Life Events

Evidence suggesting that stressful life events are related to a wide variety of physical and mental illnesses (Dohrenwend, 1974) has led researchers to differentiate stressful life events, such as the death of a loved one, a divorce, or the loss of a job, from factors that can contribute to the creation of stressful life events, such as daily hassles (Kanner et al, 1981) and changes in social supports (Caplan, 1974) and networks of supportive individuals (Lin et al, 1981). Stressful life events may occur in a variety of settings and may relate to numerous routine and variable aspects of daily life. Some are considered negative events because they are typically undesirable.

Miller (1988) contends that a life event occurs when the environment changes but the individual does not. Miller poses the question 'what makes an event significant, stressful or critical enough to be considered a life event'? Some investigators have restricted their definition of life events to personal catastrophes such as life-threatening illnesses, while others include in their definition a wide array of events whose advent is either indicative of, or requires a significant change in, the ongoing life pattern of the individual (Hudgens, 1974).

In this thesis I shall use the Brown and Harris approach to life events and their link to depression. Their approach in many ways has been the guiding light for over 20 years in understanding the role of social factors, specifically life events, in the origins of depression. For Brown and Harris (1978) and Brown (1989) life events can be seen as essentially about readjustments in thoughts, albeit provoked by something in the world and usually paralleled by some change in behaviour (Brown and Harris, 1978). The link between life events and depression has been established in a number of studies, particularly those adopting the Brown and Harris approach. These include; Costello (1982), Campbell et al (1983), Martin (1982), Parry & Shapiro (1986), Bebbington et al (1984). Whilst these

studies were located in England, a number of overseas studies have replicated Brown and Harris' findings, testifying to the cross-cultural applicability of their approach. Such studies include Fava et al (1981) in Italy, Benjaminsen (1981) in Denmark, and Vadher & Ndetei (1981) in Kenya.

Life Events and Depression: The Brown and Harris Approach

In maintaining that it is severe events that bring about depression, Brown and Harris (1978) are in no doubt that loss and disappointment are the central features of most events bringing about depression. There has been general agreement in the literature about the critical importance for depression of loss (e.g., Paykel, 1974; Finley-Jones and Brown, 1981; Miller and Ingham, 1983; Dohrenwend et al (1987). In identifying experiences of loss, Brown and Harris included: (i) bereavement or life threatening illness to someone close; (ii) an unpleasant revelation about someone close thus forcing a major reassessment of the person and the relationship; (iii) separation or threat of it, such as the death of a parent or a husband saying he is going to leave home; (iv) a major material loss or disappointment or threat of this, such as a couple living in poor housing being informed their chances of being re-housed were minimal; (v) an enforced change of residence or threat of it; (vi) a disparate group of crises involving some element of loss, for example being made redundant or obtaining a legal separation. In response to a loss, relatively specific feelings of hopelessness are likely to occur. The person has usually lost an important source of value or reinforcement, which may be derived from a person, a role or an idea (Brown, 1989). The greater a person's concern with an idea, object or person, the greater the impact of any loss, failure or disappointment concerning them is likely to be (Brown, 1987). In their study of women who developed a depressive illness, Brown and Harris (1987) found that 75 per cent of all women who developed depression experienced a severe event that matched a domain in which they had either prior marked problems or prior personal commitment. In one of his studies in Islington, Brown (1989) notes that that with one category of women who developed depression the women in question felt imprisoned in a non-rewarding and deprived setting, with the event recorded underlining how little they could do about extracting themselves, in that any way forward appeared blocked. In a smaller sub-group, some of the women had reason to feel a failure in terms of some aspect of their core identity. For Brown, the distinction between these categories was small and in effect 'one of degreee (Brown, 1989 : 27). Referring to

these findings, Moss et al (1990), suggest that the joint consideration of life events and on-going stresses in specific life domains may prove beneficial in examining the onset and course of depression. In the same vein, Craig et al (1984) and Hammen et al (1985) found that when a stressful life event disrupts the life domain in which a person has major goals, concerns and commitments, that event is more likely to have adverse mental health outcomes.

Following a review of his previous work Brown looked into the question of loss and found that loss of a cherished idea proved to be crucial in depression. It included either (1) disturbance of an expectation of someone's commitment, faithfulness or trustworthiness; (2) an event that might lead the subject to question certain qualities in herself; (3) incidents that might be even more fundamental to the person's identity. The notion of a 'cherished idea' assumes, according to Brown and Harris (1989), that ideas emerging from ordinary everyday life about oneself and one's close ties are likely to be critical for a sense of self-worth, although they may also provide a sense of security and meaning. Such ideas usually have a powerful prescriptive element concerning what should or should not be done or felt, and any failure on the part of the woman or those close to her is liable to reflect on her sense of worth and competence. Following their most recent appraisal of provoking agents, Brown and Harris (1989), developed the initial threefold classification of losses to include further categories. The first noted that it was possible to lose a person and a cherished idea. The second and third were introduced to acknowledge the complexity of the notion of loss of a cherished idea. The penultimate category dealing with loss of an idea (iv) involved loss of an aspiration. This involved a highly valued goal (e.g. miscarriage in a woman desperate for children). The categories were (i) Loss of a person; (ii) Loss of a person and a cherished idea; (iii) Loss of a cherished idea; (iv) Reconfirmation of loss of cherished idea; (v) Loss of aspiration concerning cherished idea; (vi) Material/financial loss.

Brown and Harris (1989) deliberated whether the events ushering in depression were the stuff of tragedy and concluded that whilst some of the events in their Islington study could be accurately described in this way, they no longer found the question a strategic one. Instead, they preferred to emphasise that the events always threatened some core aspect of identity and self-worth, and

possibly, leaving aside the drama of tragic events, this is what in essence defined them. Elsewhere Brown divided women developing depression after a severe event into three categories and this simpler account, according to Brown (1989), gave a useful additional perspective. In category one, the particular event in each case presented a threat to the woman's identity about which she was powerless to do anything, at least in the immediate future. In practically all the cases, it was part of a history of failure in that area of life. The second category of women had more diverse experiences, but they were all imprisoned in unrewarding and deprived settings, and the particular events served to emphasise how little they could do about getting themselves out of this situation as any way forward was apparently shut off. Brown and Harris explain that a number of these events involved housing and financial debt, others concerned physical handicap, and the consequences were frequently comprehensive. The last group of experiences involved loss of someone the women had known for a long time- frequently a close relative.

On the basis of their most recent investigation, Brown and Harris (1989), concluded that their data confirmed but also elaborated the perspective of depression provided by the aetiological model developed on the strength of their earlier studies. This included the importance of confiding support for women. Depression, therefore, often appears to be linked to experiences of major loss in adulthood as a whole and to be particularly susceptible to shortcomings in the quality of on-going social support. However, following on from one of the original Camberwell findings of Brown and Harris (1978), Harris et al (1990), noted that both childhood adversity and adult lifetime adversity turn out to play an important role in depressive disorders and that this is entirely consistent with previous analyses that have argued for the need to take a life course perspective.

Past Adversity

The role of early experience in the genesis of depression has been documented before. Parker et al. (1979 and Harris et al. (1990), note that a strand representing adverse external influences can arise from childhood adversity, but it is possible for it to arise independently at any point of the life span. This external strand in a woman's current situation is represented by factors such as major difficulties, severely threatening events and inadequate support. But these are often linked to still earlier critical

experiences in adult life such as premarital pregnancy, which in turn can relate to negative childhood experience. The link between childhood and adult diversity reported here is thus not unexpected, given this and other research (e.g. Quieten and Rutter 1984, a, b, 1988) and suggests there is a good deal of continuity, but, by and large early adverse experience only relates to an increased risk of current depression if it is linked to current adverse factors in the external environment.

This emphasis on the importance of a long-running strand of adult experiences for depression (leaving aside the role of severely threatening life events in the immediate pre-onset period in provoking an actual episode) is consistent with the results of the present analysis using the index of lifetime adversity. In this context Brown (1989) also looked into early life experience and, as might be expected, this contributed to the picture. He used an index of past adversity in terms of either lack of care or from a key caretaker in childhood, or the presence of reported marked antipathy from/towards a caretaker. Such past adversity was quite highly related to the co-presence of negativity of relationships and either low self-esteem or chronic sub clinical symptoms. However, in terms of the link between the past and subsequent provoking agents, everything was mediated by the current situation. The past was unassociated, unless there was also the relevant event-producing structure.

Following further studies similar to the original Camberwell study in 1978, Brown et al (1987) and Brown (1989a), put forward some refinements to the concept of severe events.

Some refinements to Severe Events

Brown et al (1987) note that it is a common experience that great deprivation, hardship and disappointment can be shifted more or less permanently to some peripheral part of our consciousness. One role of life events can be to tell us something central about our lives that we have known all along. The role of matching difficulties and commitments indicates the importance of the loss of something upon which one has heavily staked a part of oneself and, furthermore, that one can lose again something essentially already lost. For Brown et al the findings in their 1987 study offer some support for the conclusion of the earlier research carried out in Camberwell that it is the

meaning of *particular* events that tends to be crucial for depression and that, in so far as generalised hopelessness plays a role in aetiology, it often stems from a highly particular set of circumstances. Following their 1987 study on women in Islington, Brown et al put forward some refinements to the severity of a life event by identifying three phenomena; commitment, role conflict and matching difficulty.

Commitment

During first contact with a woman, they would be asked to discuss at considerable length five areas of her life - children, marriage (or living with someone), housework, employment and other activities outside the home. For each area she was rated on a four-point scale in terms of her *commitment.* This concerned the idea of the role or activity rather than particular personal relationships or actual current activities. Severe events matching areas of high commitment such as marriage, children and employment , were known as C-events and women with one of these was three times more likely to develop depression than those with another severe event. The greater risk of depression appears to reflect the fact that marked commitment increases the saliency of a loss or disappointment.

Role Conflict

Following a study on social roles in women, Brown and Bifulco (1985) analysed role conflicts, particularly any arising from divergent obligations, such as that between domestic and external spheres. Conflict had to be reflected directly in the woman's actual social circumstances (e.g., full-time work versus time spent with children), although its rating in each instance was based on the feelings she expressed about it (Brown and Bifulco, 1985). Thus, a high role conflict rating ('1-marked' or '2- moderate' on a four-point scale) was given where a woman reported feeling strain or psychological tension between two such domains in her life, both of which made demands on her. Role conflict was also rated where strain was reported by the women in the way she related to others: for instance, if she experienced conflict over having high hostility as well as high dependency needs in her key relationships, or if her desire to get close to people conflicted with her mistrust of others.

What do these Studies Tell Us ?

From the work of Brown and Harris and Pearlin, we can say that loss of a valued ideal or goal, particularly relating to a social role and strain over a social role are important factors in the onset of depression. Most roles are within institutions such as the family, occupation, economy, and education, where people are socialised to invest themselves in their institutionalised roles. Therefore, when people come across problems within these kinds of contexts, they are likely to react with strong concern as such difficulties experienced in important areas are not easily treated with indifference. Roles are therefore clearly important when considering life events and depression. Before going into the link between these two phenomena an overview of roles and role theory becomes both helpful and necessary.

Role Theory and Roles

As Biddle (1986) noted in his extensive review of the role theory field, although an area of diverse views, role theory exhibits an agreed upon set of core ideas, offering the opportunity to integrate key interests of researchers in sociology, psychology and anthropology. Most versions of role theory explains roles by presuming that persons are members of social positions and hold expectations for their own behaviours and those of other persons. Biddle (1979) and Burt (1982) are two authors who use the term role to refer to characteristic behaviours. Turner (1979) describes role as a "comprehensive pattern for behaviour and attitude".

Most versions of role theory presume that expectations are the major generators of roles, that expectations are learned through experience, and that persons are aware of the expectations they hold. Role theory, therefore, presumes a thoughtful, socially aware human actor (Biddle, 1986). Consequently, role theorists tend to be open to other orientations that presume human awareness, such as cognitive and field theories in social psychology or exchange theory and phenomenological approaches in sociology. In turn, role theorists adopt research methods prevalent in these orientations, particularly methods for observing roles and those requiring research subjects to report their own and others' expectations (Biddle, 1986).

Research on roles and discussion on role theory have been addressed extensively in sociological, psychological and social-psychological literature and role theory provides a perspective for discussing and analysing a number of social issues. The next section provides a brief synopsis of the main perspectives relating to role theory, followed by the author's own views and the position he will take on roles with respect to his own study.

Functional Role Theory

Begun by Linton (1936) and developed by Parsons (1951), generally speaking this approach focused on the characteristic behaviours of individuals occupying social positions within a stable social system. Such an approach sees roles as the normal expectations prescribing and explaining such behaviours. Consequently, actors in society have presumably been taught these norms and can be expected to adhere to such norms as regards their own conduct. This approach became a vehicle for explaining stability within different systems and how this induces conformity in participants. Parsons' work has been criticised in that he does not pay enough attention to social conflict and sees individual action as structurally determined. Such an approach denies human creativity and freedom by suggesting that human action is solely determined by structures. One retort to this stand-point is to demonstrate, as Berger and Luckman (1967) have done, the way in which social structures are themselves a creation of human beings. Furthermore, the theory that society is underpined by an autonomously given cultural system- laid down for example by religious values- can be rejected on the grounds that it fails to explain why culture takes its particular forms and when it changes (Biddle, 1986).

Giddens (1984) rejects the notion of "cultural determinism" associated with the functionalist approach and argued strongly against the notion that individuals are "cultural dopes" pushed around by an independently existing body of norms and rules, believing instead that people have a fine-tuned understanding of how actively to produce the sense of social order.

Symbolic Interactionist Role Theory

Pioneered by Mead (1934), this approach emphasised the roles of individual actors, the development of roles through social interaction, and various cognitive concepts through which social actors understand and interpret their own and others' conduct. Norms are believed to provide a set of general imperatives within which the details of roles can be worked out. Consequently, actual roles are believed to reflect norms attitudes, contextual demands, negotiation, and the developing definition of the situation as defined by the actors (Biddle, 1986). This approach has provided insights into relationships amongst roles, role taking, emotions, stress and self-concept and (Gordon and Gordon, 1982) how the changing of roles alters a person's goals and self-conceptions.

Ralph Turner has contributed to this field of thought by addressing, amongst other issues, role learning (1974), and the role and the person (1978). Turner (1990) defines roles as a comprehensive pattern of behaviour and attitudes, constituting a strategy for coping with a recurrent set of situations, and supplies a major basis for identifying and placing persons in a group, organisation or society. It can be thought of as consisting of rights and duties, or of expected behaviour, provided these terms are interpreted broadly. *Role-making* describes how expected behaviour is created and modified in interaction, as Turner (1964) describes it "*a tentative process in which roles are identified and given content on shifting axes as interaction proceeds*". The symbolic interactionist approach attempts to avoid what is termed the 'extreme relativism' that can potentially be implied by role making, and stresses that roles are fluid and indeterminate and that different interactions can produce a different and unique role.

Symbolic interactionism has been criticised for not recognising the contextual limits for application of their insightful ideas. Also, little formal attention is given to actors' expectations for other persons or to structural constraints upon expectations and roles.

Structural Role Theory

Within this orientation, little attention is given to norms or other expectations for conduct. Instead, attention is focused on "social structures" taken as stable groups of persons sharing the same

behaviours (roles) that are directed towards other sets of persons in the structure. The assumptions they make are simpler than those of sociologists or anthropologists, the focus being more on the social environment and less on the individual, with a more arithmetical or mathematical bent to their argument. This approach has been criticised for its apparent inability to deal with the the non-conforming individual and with social change (Biddle, 1986; Turner, 1990).

Organisational Role Theory

The focus in this approach involves roles in formal organisations. This has resulted in a version of role theory focused on social systems that are pre-planned, task orientated and hierarchical. On the basis of this approach as a result of the multiple sources for norms, individuals are often subjected to role conflicts, which produce strain and must be resolved if the individual is to be happy and the organisation prosper. Its main impact having been in business schools among industrial psychologists and sociologists, it has attracted criticism, one such criticism is that its assumptions appear to be limiting and preclude the study of roles that develop and evolve or roles generated by non-normative expectations. In addition, this perspective implies that organisations are rational, stable entities where the participant will inevitabley be content and productive once the role conflict is resolved. Such conclusions have often been questioned (Biddle, 1986).

Cognitive Role Theory

This has proved an area of extensive empirical research and is largely associated with cognitive social psychology. Attention has focused on social conditions that give rise to expectations. One area to receive attention was the phenomenon of role-taking stimulated by the work of Mead (1934), whereby people develop as social beings by imaginatively taking the roles of others such as doctors or teachers. This approach has been criticised for relying too heavily on contemporary American culture, for failing to explore the contextual limitations of effects, and ignoring the dynamic and evolving character of human interaction. In addition, cognitive role theorists, by focusing on the individual, have been criticised for under-playing role phenomenon associated with social positions or structural phenomenon.

The proponents of role theory disagree over major issues that concern the stance and scope of the field. One issue concerns whether role theory should focus attention on the person as an individual or the person as representative of a social position. Symbolic interactionists and cognitive theorists prefer the former approach and functionalists and structuralists the latter. The former approach leads one to think of roles as evolving, coping strategies that are adopted by the person, the latter perceive roles as patterns of behaviour that are typical of persons whose structural positions are similar. For Biddle, neither stance is necessarily "correct", but propositions about individuals may not be those that one would make about representatives of a social position.

Social Roles: A Summarised Account

With respect to the different approaches to role theory, I concur with Turner when he states that most generally, roles are "patterns for behaviour and attitudes" which are "socially identified, more or less clearly as an entity" and serve as a major basis for who people are (Turner, 1968:p.552).Such socially recognised complex of norms and attitudes may be associated with particular institutional statuses or with quite informal positions which tend to emerge in on-going interaction. But roles, as patterns of behaviour and sentiment which are popularly thought to "constitute a meaningful unit", may also be associated with any values held by some group or subgroup of people (Turner, 1956: p.316).Therefore, it is not only possible but useful to recognise that the career woman or feminist, or any number of idiosyncratic identities are all properly understood as roles, despite the fact that they are less institutionalised than "mother" or "wife" roles. Each of the afore-mentioned roles is surrounded by requirements which, when not fulfilled, bring challenges to the actor's status as feminist or career woman (Turner, 1990). For Benton (1993), this is to say that impulses, even when they are popularly thought to be in dialectical opposition to the norms of institutional roles, are themselves socially interpreted and grouped into recognised roles.

I also share Turner's stance when he rejects the notion of extreme voluntarism but also extreme structural and cultural determinism with respect to people's roles. What symbolic interactionists have called "role-taking", Turner argues (1962) is often better described as "role making". Actors are not merely occupants of positions for which there are neat sets of rules; rather, actors take part in "a

process of devising and discovering consistent patterns of action" (Turner, 1976:p.26), patterns of action which are then recognised as roles. Role making, then, is not merely the absorption of social norms and requirements. It is every individual's progression as he or she takes part in social interaction. As a result, individuals construct both roles "in part on the basis of unique experience and in part in accordance with the guide-lines shared by members of his/her society, sub-society, and groups" (Turner, 1976:p.1011).

There exists, then, the potential for a number of potential role outcomes, depending on the person's views, cultural values and social situation. I shall address three such outcomes which Turner (1990) lists as possible developments for role outcomes; role conformity, role change and finally role conflict.

Role Conformity

A great deal of writing on role theory suggests that conformity is a good thing, that social integration and personal satisfaction are greater when persons conform and imitate the behaviours of others. Lying behind this is the concept of expectation (Biddle, 1986). The idea that expectations generate behaviour is contained in most versions of role theory and are found in functionalist, symbolic interactionist, organisational and cognitive role literature. Behind much of this writing is the belief that conformity is a good thing, that social interaction and personal satisfaction are greater when persons conform to others' expectations. However, enthusiasm for conformity is also mixed. Symbolic interactionists often question the degree to which roles are actually generated through conformity. Numerous studies have shown that commitments can and do favour non-conformity and the questioning of traditional expectations (Biddle, 1986).

Much of the research on conformity has been American based. But people like Turner (1976) suggest that Americans are less driven by norms and more affected by preferences than they were in earlier generations. Furthermore, the cultures of modern societies are frequently fragmented, containing diverse and inconsistent elements, and different groups may adhere to different elements. This Biddle (1986) suggests reflects the decline in the importance of community, church and family. For Turner

(1990), conformity is by no means a certainty, and its appearance reflects somewhat different processes depending on the modality of the expectation involved.

Role Change

Role change can be defined as a change in the shared conception and execution of typical role performance and role boundaries. Roles can change in several ways. A new role can be created or an established role can be dissolved; a role can change quantitatively, either by the addition or subtraction of duties or rights or by a gain or loss of power or prestige..... and a role can change qualitatively by a change in the relative salience of its component elements, by substitution of elements, or by re-interpretation of its meaning (Turner, 1990).

The initial impetus to change may come from a widespread lack of fit between role and person with respect to functionality, tenability or representational character of the role. The lack of fit may come from a change in attitudes, abilities, or resources of recruits, or the impetus may come from change in the environing social structure. This can lead to changes in the availability of resources and social support for performance of the role. There may be change in cultural values, as they apply to the role and to its various goals and functions. Turner (1990) notes that one or more often several of these conditions appear to have caused the initial destabilisation that created an impetus to role change.

Flowing from this realisation, Benton (1993) notes that the pluralisation of life-worlds in an institutionally complex society, surrounded by change and variety, encourages us to experience ourselves as actors, moving across a series of stages upon which we play different roles. To the extent that community membership or institutional statuses are either destabilised or trivialised (i.e., the degree to which they no longer make any substantial and lasting difference to a person's life-course), they will no longer be prominent elements in personal identity. Furthermore, states Benton (1993), there is little question the fate of a person brought up in a cosmopolitan environment is less specifically determined than a person brought up in a more thoroughly homogeneous traditional society.

In relation to role change, Turner (1990) draws attention to cultural changes in Catholics in the USA as reported by Hoge (1981), where Hoge speaks of " *a great reversal, in which the ghetto Catholicism of the immigrant era was replaced by a middle class Catholicism that embraced American culture*" (p.25). Turner states that this role incumbent change from the assimilation into American culture caused a shift away from traditionally expected docility toward acceptance of selectively regarding beliefs and exercises as appropriate for Catholic laity.

Turner (1990) cites a number of conditions for implementing a new pattern of roles which includes "cultural credibility of the proposed new pattern of roles", including compatibility with the values of contemporary social movements. If, however, the impetus to change involves or affects encroachment on one role in what is conceived as the territory of another role, the process of change becomes competitive.Turner also notes the impetus to change can be seen in "*the misfit between role and person, brought on by demographic changes and reinforced by cultural change*" (p.101). Later he states "*recently women's opportunities outside the family and options within the family have multiplied, and cultural role conceptions have been adjusted*" (p.103). Turner and others have linked this to education expanding women's horizons, making the distinction between men's and women's capabilities less credible. Feminism has also contributed to this development. "*It is the incomplete and uncertain stabilisation of a new pattern of gender roles, both within and outside of the family, that can shed more light on the dynamics of role change*" (p.103). In addition, Turner notes that there are a number of obstacles to role change and that this resistance can come from both men and women. It is clear, therefore, that the change is uneven in this respect.

The impetus towards role change can be set in motion by a change in the cultural value assigned to the focal role or to its various goals and functions, a social structural change that modifies the demand for role-relevant services or affects the availability of resources or social support for performance of the role. Whether the impetus will lead to successful negotiation of a new role pattern depends on several conditioning factors, which include the cultural credibility of the potential new role pattern and success in gaining support for the change (Turner, 1990; 107). If conditions are favourable, the outcome is role change. Such restructuring and stability are, however, relative rather

than absolute and role change is not always the outcome. Accommodation is always relative rather than absolute, as are stability and change.

Turner then turned his attention to what can potentially happen when a person defines his or her role in one way while those in related roles define it differently. What happens when others do not hold consensual expectations for a person's behaviour ?

Role Conflict

When a person defines his or her role in one way while those in related roles define it differently, one possible outcome is that those others are formed into sets of persons whose expectations are distinct and incompatible. In such cases, it is argued, the person will be subjected to conflicting pressures, will suffer stress, will have to "resolve" the problem by adopting some form of coping behaviour, and that the person and system will both be disrupted.These ideas have given rise to the concept of role conflict which Turner defined as the concurrent appearance of two or more incompatible expectations for the behaviour of a person (Turner, 1990).

Flowing from this, Turner (1990), draws attention to the many writers who have argued that women in western societies are subjected to conflicts between expectations associated with traditional roles, such as home-making, and those for occupational or professional careers. These arguments have also supported studies demonstrating the prevalence of role conflicts and associations between role conflicts and stress for women (Stryker and Macke, 1978; Lopata, 1980; Skinner, 1980).

These and other studies indicate that some role conflicts are stressful. When this happens how does a person cope with the situation? Hall (1972) discusses three types of response: negotiating with others to change their expectations; restructuring one's views so that the problem is less troublesome; and adjusting one's behaviour. This is feasible, and does happen. This means that individuals can resolve incompatible ideas on roles by engaging in some of the processes Hall (1972) refers to. On the other hand, negotiation, adopting one's behaviour or changing one's views is by no means inevitable and

not always possible. As Biddle (1986) points out, role change can involve incompatible beliefs, preferences or internalised norms which can lead, in turn, to role conflicts.

Pearlin (1983) believes that the changed circumstances of roles with which people have to cope in their everyday lives are in fact highly related to stressful experiences. In an interesting follow on from Brown and Harris's criticisms of some aspects of life events research, Pearlin (1983), contends that the fact that life events can exert their effects directly through their influence on roles does not mean that we do not pay considerable attention to events. What this means is that when life events are considered as antecedents of stress, they should be viewed in conjunction with a consideration of roles. Focusing on roles as a source of stress, should bring the part played by life events in the stress process into what Pearlin calls a "more balanced and interesting perspective" (Pearlin, 1983).

Brown and Harris on Social Roles, Role Conflict and Depression

Following their initial Camberwell study in 1978, Brown and Harris, and Brown and others, deepened their understanding of the processes involved in depression and developed their theories, with implications for their original model. One area that emerged as playing a critical role in depression was role identity.

The work of Brown and Prudo (1981), and Brown et al (1981) among Hebridean women highlighted the role factor and extended the knowledge of variables involved in depression, particularly across different cultures. On the basis of work among Hebridean women the research teams found a higher rate of depression among those women who had moved away from a traditional life style, in this case crofting and regular churchgoing. It was concluded after detailed examination that the differences in onset of depressive disorder between the traditional groups and non-traditional groups highlighted socio-cultural differences, particularly in terms relating to family structure, marital position, and contact with relatives in terms of theories of attachments, especially cultural variations in attachment patterns.

Following their original research in Camberwell, Brown and Harris (1978) emphasised the importance, if depression is to be avoided, of locating alternative sources of value, and that the location of these will clearly relate in a particular cultural context to the structure of social roles and expectations surrounding them. The research teams in the Hebrides noted the limited roles available to Hebridean women which mainly centred on the traditional ones of mother, daughter, wife, and sister. The importance of loyalty to one's family was also of central importance in Island life. Following the death of a close relative the risk of depression was greatly increased in traditional Hebridean women. Brown and Prudo (1981) believed this revealed that death of a close relative threatened the roles of these women, depriving them of a vital source of self-esteem which, under normal circumstances, contributes to a lower risk of depression. This situation differed among London women as it was believed the metropolitan culture sanctions re-marriage and provides a population centre so large that alternative relationships and attachment figures are more available. However, subsequent studies among working class women in London have also revealed the importance to women, in a different context to Hebridean women, of their role and how conflict arising from divergent obligations, particularly between domestic and external sphere, was related to risk of depression.

Brown et al (1981) and Brown and Prudo (1981) also found that women in the Hebrides who moved away from a traditional lifestyle had a higher rate of depressive disorder than those who maintained a traditional lifestyle. The research noted the limited roles available to Hebridean women and family expectations surrounding such roles. The differences in rates of depression between traditional and non-traditional groups highlighted the importance of family structure, marital position and cultural variations in attachment patterns. Having a traditional lifestyle was linked with a source of value which, in turn, was linked with self-esteem. It was concluded that satisfaction with one's role in life is an important factor in offsetting depression (Brown et al, 1981; Brown and Prudo, 1981).

Pearlin on Social Roles, Role Conflicts and Depression

Stresses linked to institutional roles cannot be anything but crucially important both to the lives of individuals and the structure and functioning of the social system. In addition Pearlin, whilst not wishing to challenge the importance of stresses whose roots are outside social roles, contends that roles are also attractive to the stress researcher because they represent areas where a number of social forces come together, with the result that they reflect the properties of the broader contexts in which they are located (Pearlin, 1983).

In developing his position, Pearlin (1983), examines the notion of role strain, a concept he employs to refer to the hardships, challenges and conflicts that people come to experience as they engage over time in social roles. Because roles are usually embedded in role sets, the potential for conflict among those sharing the role set is considerable. Many of the frustrations and difficulties of people can be traced back to their encounters and confrontations with others sharing the same role sets. Pearlin notes, however, that in order to achieve a complete picture of role strains it is not enough to look at the role alone but one must also take account of the subjective directions individuals bring with them into their roles. Whether or not these conditions are experienced as harmless or as hardships often depends on how individuals' subjective values and personal aspirations combine with the conditions. Conflicts that are experienced within roles may grow directly out of problems, hardships, personal frustrations or insults to personal identity that are built into the role. What determines whether a role will be stressful often depends on how it fits with what people's goals are and consider to be desirable. Consequently, the same set of objective conditions can affect people differently, depending on the favourability or incompatibility between the conditions they face and their values (Pearlin, 1983). In recognising that role strain can result from different types of role situation, Pearlin addresses the question of role conflict where individuals are bound to one role while wishing to play another. The essential feature of this phenomenon is that the role is unwanted, regardless of the conditions it presents. It's essential characteristic is that it entails an unavoidable obligation to be and do one thing at the very time the individual wants to be and do something different. This conflict generates stressful experiences and, in the absence of mediating resources (especially social support) can lead to depression (Pearlin, 1981; 1983).

Pearlin's interest in this area flowed from his research into sex roles (Pearlin, 1975a). From his research it appeared that women more than men are susceptible to certain types of psychological distress, particularly depression. Pearlin also notes that gender is a characteristic that influences the stresses to which people are exposed and that women and men often experience different stressful circumstances (Pearlin, 1989). There has been much speculation as to why this should be so. Pearlin, on the basis of his earlier research believes that an important issue in what affects a woman's psychological well-being is the consistency of what she does with what she wants to do. The conditions that people experience in their roles, therefore, should be seen in conjunction with their values and aspirations in order to understand fully how conditions of roles become antecedents of stressful conflicts (Pearlin, 1983).

Other Studies on Social Roles, Role Conflict and Depression

Role conflict has been associated with undesired personal outcomes, dissatisfaction, low commitment and low performance. In short, the experience of role conflict is affected by the likelihood that important consequences depend on the role incumbent's choice between conflicting expectations (Siegall, 1992).

Khan et al (1964) noted that the typology of role conflict involved the "*simultaneous occurrence of two or more sets of pressures such that compliance with one would make more difficult compliance with the other* "(p.19). He suggested that role conflict involved inter-role conflict- incongruent expectations from members of two or more different role sets; and person-role conflict-incongruities between expectations of one or more members of the role set and expectations within the role incumbent's subjective role.

Kandel et al (1985), following their research on the stressfulness of daily social roles for women found that strains and stresses were lower in family roles than in occupational or housework roles, but when they did occur they had more severe consequences for the psychological well-being of women than occupational strains and stresses. Strains predicted distress through role-specific stress, with

strains deriving from inter-personal conflicts making the strongest contribution to role-specific stress. They found that feelings of dissatisfaction with interpersonal interactions, especially in family roles, were the most stressful (Kandel et al, 1985).

In a study of sex roles and depression, Glazebrook and Munjas (1986), observe that men and women are socialised to conform to stereotyped standards of masculinity and femininity but that men and women are now finding that roles assigned only on the basis of gender are restricting. With the addition of new behaviours, the risk of role strain increases (Goode, 1960). Individuals may experience conflicting expectations with the assumption of new roles which cause a conflict between internal values and the external demands imposed by society to create role strain. Glazebrook and Munjas (1986) believe that if individuals accumulate new roles without resolving conflict between personal and societal values, they experience increased individual demands. In order to resolve this conflict, individuals must relinquish or re-negotiate roles that are not personally satisfying rather than adding new behaviours to the old. If they attempt to meet all the demands created by multiple roles, increased stress and role strain will be experienced (Garnetts, 1979; Stuart, 1981). Glazebrook and Munjas (1986), found that women who experienced conflict in sex roles also experienced with higher levels of depression. They believe that behaviours and roles that contribute to role conflict can be examined and more adaptive behaviours and roles substituted where possible.

Role conflict has been associated with undesired personal outcomes, dissatisfaction, low commitment and low performance. In short, the experience of role conflict is affected by the likelihood that important consequences depend on the role incumbent's choice between conflicting expectations (Siegall, 1992). In a study on the effects of role conflict source on the experience of role conflict, Siegall (1992) concluded that the amount of experienced distress resulting from intrasender role conflict was affected by the conflict sender's power and importance. The reported amount of conflict also varied by the conflict sender's power and importance. The degree to which expectations were seen to be in conflict was a function of who communicated the conflicting expectations. The relationship between perceived conflict and experienced distress was stronger with more important

senders. In short, the creation and impact of role conflict may not only be a matter of what people tell you, but who is telling you what (Siegall, 1992).

Greenglass et al (1988), found that women were more likely than men to experience role conflict between their familial roles (those of wife and mother). They state that such role conflict stems partly from stereotypes regarding appropriate feminine gender-role behaviour. They found that women's lives were disrupted more than men's when role conflict was high and that this was also related to higher levels of depression. Poole (1991) notes that the attitude of a husband towards contributing towards the wife's career success remains a significant factor in affecting the qualitative aspect of women's roles, their role choices and opportunities for successful negotiation of role conflicts.

Cook (1990), reviewed the literature on gender and psychological distress and argued that gender influences not only what is experienced as problematic, but also how psychological distress is manifested. The increasing acknowledgement of the gendered nature of experience has been an important theoretical advance in recent literature. The stresses associated with women's role as home-maker have been described in detail by a number of authors (Oakley, 1974). Many studies find that occupancy of the role of parent per se does not contribute to women's overall satisfaction with their lives (Ver brugge, 1982).

What Does This Overview of Stress, Social Roles and Life Events Tell Us ?

Life events can be stressful by adversely affecting or changing aspects of key social roles. Roles can be seen as patterns of behaviour and attitudes which serve as the basis for who that person is. The development of a social role is a complex process involving both the absorption of a range of social norms and requirements and also the product of social interaction. As a result a social role is developed in part on the basis of personal experience, a person's views and cultural values and in part in accordance with guidelines shared with members of the society, sub-society, groups and sub-groups that person comes into contact with. This relationship can occur in a dialectical form with one side feeding on other and vice-versa. There exist a number of possible outcomes from such encounters - role conformity, role change and role conflict.

The conditions that people experience in their social roles become of critical importance when taken in conjunction with their values, goals and aspirations. This approach helps us to understand how and why social roles can, under certain circumstances, become associated with stressful events. Such a scenario can develop where a role is unwanted, where a person is bound in one role while wishing to play another, and where a person is unable to engage in role change as a result of various social pressures. Loss and disappointment are central features of most stressful events. The notion of loss does include loss of a person and material/financial loss, but, critically, it is loss of a cherished idea, loss of aspiration concerning cherished ideals and values, and loss of a valued goal that are critical factors in the aetiology of depression. Furthermore, where an event occurs that matches a domain in which the person has a personal commitment and/or where people find themselves in non-rewarding and deprived settings from which they can see no escape, the risk of depression increases. Social roles play a critical part in the life event process in that loss of a valued idea, goal or aspiration relating to a social role can lead to role strain/conflict which can, in the absence of social supports (especially a confiding relationship), increase the risk of depression in women.

Evidence from the work of Brown and Harris (1978; 1981; 1987) and Pearlin (1981; 1983; 1989) indicates that events become stressful by adversely affecting changing social roles. As was shown in Chapter 1, the above research findings on role conflicts and their association with stressful life events is not confined to white indigenous women. For the purposes of this thesis such findings take on a special significance when one looks at research findings which have uncovered mental distress (notably depression) among second-generation South Asian women in Britain and have shown a link between depression, stressful life events and conflict and strain over social roles (Mumford, 1991; Merrill 1990; Beliappa 1991).

Whilst the concept of loss is of critical importance, there are a number of situations where experiencing a severe event without loss can be implicated in depression. These events tend to be acute, unexpected events such as being attacked in the street or being informed of an unplanned pregnancy. There are also a restricted class of major difficulties (which have lasted for at least two

years) which also appear to be involved in the onset of depression. Lastly, it appears that past adversity, especially marked antipathy from a key caretaker is also implicated. As with loss, such events do not automatically lead to depression, the role of support, especially a confiding relationship, has a critical bearing in the development of depression .

Section 2

Introduction

This section looks at the events which have played major roles in women's lives and classifies women according to dominant kinds of life events they have experienced. Among depressed women three categories of event emerged (1)Severe events involving loss (2) Severe event without loss and (3) On-going major difficulties. Some of the non-depressed interviewees had experiences not dissimilar to the depressed interviewees and I shall explain the differences between the two groups.

(1) Severe Events Involving Loss

The biggest category of severe event was loss, with 17 out of the 23 women interviewees featuring in this category. There were two sub-groups in this category. The first and largest was women who experienced loss of valued goal and aspirations relating to a social role. This group appear under the heading "Loss Through Role Conflict" and included 12 women. Some women in the non-depressed group also experienced role conflicts but the nature, strength and duration were different from those experienced in the depressed group. I contrast the experiences of both groups and explain why there have been different outcomes with respect to their mental health.

The second sub-group experienced loss through a number of specific but separate events which were loss through death, loss through miscarriage, loss through separation and loss through family dispute. This group are categorised under the heading "Loss Through Specific Events" and included five women.

(2) Severe Event Without Loss

One woman came under this category, described by Brown and Harris as severe unexpected events not involving loss but traumatic enough to count as a severe event and act as a provoking agent in depression. In this study the woman experienced sexual harrassment.

(3) On-going Major Difficulties

These involved a restricted set of difficulties called major difficulties which had lasted for over two years and had become chronic problems. The variable in question emerged as intra-family disputes of a long-term nature and included five women.

When referring to the interviewees I shall do so by where they are from, their religion and a number. For example gm1d is Glasgow Muslim Depressed Interviewee number 1. The abbreviations are;

gmd = Glasgow Muslim Depressed

gsd = Glasgow Sikh Depressed

ghd = Glasgow Hindu Depressed

ehd=Edinburgh Hindu Depressed

emd=EdinburghMuslim Depressed

esd= Edinburgh Hindu Depressed

Where nd is stated, this refers to non-depressed.

(1) Severe Events Involving Loss

(a) Loss Through Role Conflict

The twelve women in this category experienced strong forms of conflict involving three areas of their lives; educational aspirations, boyfriends/marriage, and employment/careers. In four instances the conflict began with the women's parents and continued into their marriage with their husband. Four cases involved husbands only and three cases involved husband and mother-in-law, one case involved husband and husband's family.

This conflict centred on the expected roles, behaviour and attitudes of the woman before they were married, on the question of marriage, and continued into their marriage. Many of these women did not agree with, were unsatisfied with or had difficulty conforming with their parents'/husband's/mother-in-law's expectations of what their role should be and, consequently, how they should act. The values and intended roles of the women were at odds with those promoted by their parents'/husband/mother-in-law as well as their community generally. Many of the women expressed concern at the way they were expected to uphold the 'honour' of the community and family and felt that, as well as being unfair in that it did not apply to men to the same extent, it could and did place restrictions on the way they led their life.

I have selected three interviews (which I quote at length), to give a flavour of some of these conflicts. A synopsis of each interview covering the key issues is contained in the appendix. The experience of role conflict was also found with the non-depressed interviewees and I include some of their comments and contrast their situation with the depressed sample for the sake of comparison.

The first interview quoted is a Glasgow Muslim woman (gm6d) who had hoped to go to university but her parents had wanted her to leave school at 16. She had maintained her desire to go to college and obtain qualifications for further education but this conflicted with her husband's views of her role as wife and parent.

gm6d

"I received very little affection from my parents, I was the eldest and it was always do this, do that, do the housework, it was awful. I had no encouragement, no support, I was there to do as they said..... It was getting frustrating, even if I did go out it had to be with someone. The first time I was in a post office I was 18 years old. On T.V. even in Asian films, women had more freedom. I was angry, always arguing, no give and take at all. It was very frustrating. It was like a brick wall, there was no movement.

I was told I had to get married because I was getting old. My God I was 22. I didn't want to get married and especially to the man who is now my husband. He has very strict ideas on how women should act... I don't share them. We live near where all his family live, all his sisters and sisters-in-law go along with things but I know from talking to some of them that they feel the same as me. I spoke out once when we were all together and I was scolded by my husband in front of them all.

Now I live a life that has no real appeal. I am a predictable housewife. I tried to talk my husband into spending more time at home so I could go to college, but it always ended up in a big argument. I think he is jealous because he knows deep down I am cleverer than he is. My guidance teacher at school told me I could be anything I wanted. I could go into English, Art, Science. I think I could have. They all still interest me. That period of my life is still strong with me It makes me feel bitter angry. I look at my father's friends daughters and they are doctors and pharmacists. Those were my dreams and I suppose still are..... I really thought I was going to go to college, he (the husband) *did agree to it a few months ago then we had a fight and he changed his mind. His family even started having a go at me, saying I should*

be at home with the children....Don't get me wrong I love my children but I have a life as well.... I don't know if I'll ever make it now"

The next woman is an Edinburgh Muslim (em1d) who had been in dispute with her husband over her wish to hire a childminder to look after their children while she went out to work. She was also very conscious of not being able, or willing, to meet the requirements of a 'good housewife'.

em1d

"When I got married I thought this was the person for me. I had been married before and it was a disaster. I wanted a family and a husband that loved me.We worked hard, bought a small shop where my husband still works. I gave him my savings. I fell pregnant, then my husband called his brother over from Pakistan. When he came over things changed completely between my husband and myself. I became a second-class citizen, his family were number one. Part of the problem was that I didn't know all the cultural things like how to act towards my brother-in-law. My husband expected me to act in a certain way.... he had come over from Saudia Arabia and it was his first time in a country like Britain. I agreed at the time that his brother could come and stay with us but I really had no say at the time.

"He expected me to look after the two of them, I was seven months pregnant- he should have been looking after me. . My son was born. I had no time with him, I had to look after two men. I had no support in bringing up my son. Living all the time in the house.. I tried to go back to work and I did for about 6 weeks. We got a child-minder in. But my husband said 'no more childminder: only mothers can look after their children'.... I gave up working, I was really upset about that..... work gave me a sense of satisfaction, a sense

of achievment, it gave me time off from the baby. .....I look back at at how it was in the past and compare it to now..now it is nothing."

The next interviewee is a Glasgow Hindu who was in dispute with her husband and mother-in-law over her behaviour not meeting their expressed wishes.

gh1d

"Me and my husband had a really loveable, good relationship I could talk to him, was close to him. But it started to go all wrong when his mother came over from India. Her husband died and she wanted to come and stay for good. None of her other sons in India wanted her. I wasn't looking forward to it. She didn't respect any privacy, she wanted to dominate all the time, she'd always done it in India I think it was her personality, she was a really mean person. She started interfering all the time One time she went through my handbag. She found the pill (birth control pill) and asked my sister-in-law what they were. She was annoyed when she found out. Then I knew the times that she had been in my room looking for things. Things were bad almost as soon as she arrived .... with all the interfering my husband started going out all the time. I couldn't take it any more, my husband was never in, he started to go out all the time.

"He says I'm too westernised that's why she doesn't like me- I'm too outspoken as well. I've worked all my life with Scottish people and have many Scottish friends. If they invite me to parties and that, I go although I don't go to pubs. He minded me drinking in front of his mum because an Indian women shouldn't drink or smoke or go out with friends. I love going out with Indian and Scottish friends. With Scottish people you are so open-minded and joke about anything. I'm Asian but I've never had any problems with my Scottish friends. I invite them over to the house for a curry quite a lot, I have some wine, it's a good laugh.

"Indian people keep themselves to themselves. When I meet them they want to talk about clothes and jewellery they are not as open and you don't get as good a laugh. Asian women don't go out as much especially those staying with their mother-in-law. Every time they want to go out they need her permission. I don't think that's right. Once you're married that should be it. I'm just a human being, I don't feel Indian though I pray to our gods, cook Indian food and dress in Indian clothes a lot.....I think I'm different from Indian women in that I drink a wee bit wine and go out, I'm more open. But I am Indian. He's blaming my Scottish friends for me being so outspoken and going out... He and his mum think I should be a certain person. It has gone downhill completely now, my husband has left and taken his mother with him, thank God,.....I think why? Why can't he accept who I am?"

The woman was determined to '*be herself*', the relationship became violent and she was attacked and stabbed by her husband. Following failed attempts to patch up their marriage the couple separated. She found the separation very difficult. She went through all of this with virtually no support. She could confide in her sister but she lived in Dundee and did not like to 'burden her'.

The next interview quoted is from an Edinburgh Hindu woman who wanted to set up her own business with a friend. This resulted in repeated arguments with her husband.

eh2d

"My friend and I have talked about setting up our own business in the line of health and beauty care.... she knows a lot about beauty and I know a lot about aromatherapy and massage. It is something I have thought about for years ever since I started going to some classes. She has already got the go ahead from the bank but is waiting for me. The problem is my husband is dead against it. He

thinks I should wait until the children have grown up..... They are only young, why should I wait? It's something I've always wanted to do but he cannot accept that you can have a family and a life outside your family. I've told my friend to go ahead without me, I can't keep her waiting for ever. So now I'm left to do the normal thing..... sometimes the boredom drives me up the wall. Our relationship has suffered."

The final interview in this selection is with a Glasgow Muslim woman (gm4d) who had the qualifications to go to university but who became pregnant, against her own personal wishes and was now housebound with a child to look after, frequently visited by in-laws she did not get along with.

gm4d

"I have always wanted to go to university. When I was at school two of my Asian friends .. (Muslims with Pakistani parents) were going to university and two other friends who were white were also going to go. Two were wanting to study medicine, one law and the other pharmacy. I wanted to do pharmacy or medicine. I did well at school although I had a huge fight with my dad about staying on when I was 16. It got so bad that I ran away. It was only for one night but it was a big deal. I told him that I would leave for good if I wasn't allowed to stay at school. I told a teacher at school and she came round to talk to my mum and dad. After that things were alright but an agreement was made that if someone was found for me to get married, I would get married.....Surprise, surprise, they found someone. I should have known.

"He was a typical guy, he was from Glasgow but he had strong views about me being his wife..like my father, I thought..... He is okay, he runs a shop his father owns and is really busy so I never see him. Only at morning and night when I prepare food for him. We talked about me going to university and at first I

thought he would be in favour but he spoke to his family and said we should start a family. I was not wanting to. We fought. His parents spoke to me so did mine, I was being selfish, only interested for myself... I told them if I went I would get a good job and bring in more money. Nothing changed.....When I found out I was pregnant it was the worst day of my life. I had taken things the morning after and had visited the doctor about taking the pill, but if anyone found out I would be in big trouble. I was too scared so ....I ended up pregnant. I love my child, but I wanted children much later. Now I meet his sisters and in-laws, it's so boring. I don't keep in touch with my school friends. He (husband) doesn't like me seeing them but I would feel worse knowing what they are doing with their lives. None of them are married. I bumped into one of my friend's sisters in the street, she told me what she (her friend) was doing. She was at university, had a flat, had a boyfriend, went on holiday. I looked at myself and said "my God". "

This selection of interviews is a reasonable representation of the women in the 'Role Conflict' category. These are woman with very specific and in most cases deeply held aspirations but have found them blocked. This process has in itself often resulted in conflicts with parents/ husbands and/or in-laws. The women find themselves in positions they dislike, performing tasks and duties they dislike and which are significantly removed from their own personal goals, values and aspirations. The woman above, like the rest of the depressed women in this category, has weak or very weak support and therefore bears these conflicts on her own. As I shall demonstrate this is an important factor because there were women in the non-depressed group who experienced role conflicts, but who had support throughout the experience which turned out to be a crucial difference. I shall compare some of these experiences in the next section. To make things easier, I have produced a set of tables summarising the strength of the conflicts and whom the conflicts were with. (One can also examine the major table in the appendix to see the strength of the social supports in both categories of women, which I will discuss more fully in Chapter 5).

'Role Conflict' in Depressed and Non-depressed Women.

Table 1: Role Conflict Strength (depressed group)

***= present**

****= strongly present**

Women	Upbringing/ Schooling	Staying on at school	Boyfriends /Marriage	Further Education	Work
gm4d	*	*	*		**
gm5d	**	**	-	-	**
gm6d	**	**	*	**	**
gm7d	**	*	*	*	**
em1d	**		*	**	**
gh1d	-	*	-		**
gh4d	-	-	**	*	*
eh2d	-	-	-	*	**
es1d	**	**	-	**	-
es2d	*	*	*	-	**
gm11d	*	*	*	-	**
em2d	*	*	**	*	*

Table 2:Other-Party to Conflict

Depressed Interviewees

Women	In conflict with
gm11d	Husband
gm4d	Husband and Husband's Family
gm5d	Parents then Husband
gm6d	Husband
gm7d	Parents then Husband
em1d	Husband and Mother-in-law
em2d	Parents then Husband
gh1d	Husband and Mother-in-law
gh4d	Husband and Mother-in-law
eh2d	Husband
es1d	Parents then Husband
es2d	Husband

Table 3 Role Conflict, (Non-Depressed Interviewees)

Women	Upbringing/ Schooling	Staying on at 16	Boyfriends	Marriage	Career
gm5nd	*				*
gh1nd	-	-	-	*	*
em3nd	**	-	**	**	-
gm8nd	-	-	-	-	**
gh4nd	-	-	-	-	*
gm7nd	-	-	-	*	*
es1nd	-	*	-	-	*

Table 4 Role Conflict: Other-Party to Conflict (Non-Depressed Interviewees)

Women	**In conflict with**
gm5nd	Husband and parents
gh1nd	Husband
em3nd	Parents
gm8nd	Some in-laws and sections of community
gh4nd	Husband's relatives and neighbours
es1nd	Some in-laws and sections of community

The tables above demonstrate that role conflict occured in both groups and that within both groups the source and strength of the conflict varied. There were important differences between the two groups in the strength of the conflict, the source of the conflict and the duration of the conflict.

Strength and Outcome of Conflict

Compare Tables 1 and 2 with Tables 3 and 4 we can see that those in Tables 1 and 2 (depressed interviewees) had a much higher occurrence of strong role conflict. Out of 11 cases, 8 experienced strong role conflict from more than one source. With those in Tables 3 and 4 (non-depressed), only 1 out of 6 experienced strong role conflict.

Interviewee em3nd experienced strong role conflict on upbringing/schooling, boyfriends and marriage. She did not, however, develop depression. This is a Muslim women of Pakistani parents, born in Edinburgh and married with one child. She had difficulty adjusting to her parents' demands and how she felt she wanted to behave at and outside school. When aged 18 she fell in love with a young man who, like herself, was born in Edinburgh of Pakistani parents. They wanted to marry. Her parents were totally opposed to this 'love marriage'. She felt that her parents were '*trying to decide my life for me*' she wanted to continue working and marry the person she loved, her parents wanted her to stop working and get married. For her, the central issue was '*Me deciding who I wanted to be and what I wanted to do'* She went ahead and got married and had great support from her friends. As she told me in the interview, her parents' attitude changed:

em3nd

> *"My parents' outlook changed because of what I did. They realised they'd have to compromise. I think respect is the key but I left home to get what I wanted. It's what I want that's key. Parents realise that girls will leave home if they are forced to do things. They try to condition you to be the person they want, but things happen - life changes you. My mum is more compromising now. Not so many people I know talk about running off if they are with their parents because they are staying and arguing for what they want."*

This woman, apart from having strong support from her friends was also a member of an Asian women's group which, she said, gave her '*great help and encouragement*'. Her parents did not take that long to change and before long she was re-united with her mother and father. Her sisters had supported her through all the turmoil. Therefore although she had experienced strong role conflict, she had strong support throughout it and the conflict was resolved when her parents came round to her way of thinking.

The outcome of this case contrasts with that of one of the cases in the depressed group gh4d whose experience was similar to em3n. The woman in question was a Hindu women born in Glasgow of Indian parents. This woman had met and fallen in love with a Scottish man whom she went out with for two years without her parents' knowledge. The woman decided she wanted to marry this person. She took her boyfriend to her father and they told him they were to marry. The father and mother were totally opposed to the idea of her marrying a non-Asian.

gh4d

"After that the atmosphere in the house was terrible. My dad didn't care about my feelings, he said I was being selfish..... he kept saying 'what will other people think- what about your brothers and sisters. My boyfriend wanted to keep things going..... I couldn't stay with my mum and dad any longer. We were going to go ahead and get married: right up to the last minute they said 'leave and we'll never see you again.' I couldn't leave ... it wasn't so much that I would never have seen my parents again it was my brother and sisters. It was really traumatic, I went down to London and got a job.... then I was really mad. I wrote my dad a really nasty letter telling him he wasn't understanding... I couldn't understand why the community was more important than me ... I hated him for ages after it. It took me about six or seven months to get over it."

"I had to deal with it myself because I was in London and had no friends. I couldn't even speak to my sisters about it because they were living at home and it was still

taboo even though we had broken off..... I heard recently that he had got married. I pretended I didn't care but I cried my eyes out.....He was my first love so I suppose that's got something to do with it.

The women eventually returned to Glasgow still '*bitter*' at what her parents had done. She got married but had '*no real enthusiasm*' for it. Apart from not seeing her Scottish boyfriend again, she lost touch with all her close friends as they were also her boyfriend's friends. The woman, who had a degree was unhappy in her job. She wanted more from her career. She and her husband have arguments over this, particularly relating to her looking after the children. The woman had a serious conflict over her own role and what her parents thought was best for her. It was unresolved, she went through enormous difficulty and did so unsupported, without help from friends or family. The outcome for her was not particularly positive. She went into a marriage she had '*no real enthusiasm for*' and has arguments with her husband about her role.

The important difference between these two examples is that gm3n had strong social, confiding and practical support and her conflict was resolved, whereas gh4d had no support, and the conflict was unresolved and continues through to today.

In the depressed group, seven of the cases experienced conflict from the past into the present. Four of the group experienced conflict in the present. I shall now look at another example of loss through role conflict and compare it with an example of role conflict in a depressed woman. A non-depressed Muslim woman in Glasgow (gm8nd) and a depressed Hindu woman (gh1d) in Glasgow, both of whom described to me conflict in their roles.

The Muslim woman in the non-depressed category (gm8nd) was experiencing conflict over her desire to be a police woman. She was currently working as a 'police special', a voluntary post which entails working (in the company of a police man/woman) as a police officer, with police powers. There was great talk of this where she lived, a predominantly Asian area, and most of the talk was not favourable. She was receiving criticism from local people and her parents were constantly being

asked 'what she was up to'. She told me about the 'shock' some people had been in when she went out jogging in the park as part of her training.

gm8nd

> *"Since I started working I speak out more, I'm less shy and have more confidence. At school I was more Asian than Scottish. Since working its the other way around. Work is important to me, a housewife's life is boring. I want a career. I know other Asian women who want to have careers but can't because they have been married off. When I started working I used to dress traditionally, then I got this job and my boss said to me ' why are you wearing leggings under your skirt, what's the point' She was really rude- racist. So to mix with the rest of the work I dressed in Scottish clothes. But people started stopping my mum in the street and saying 'what's happened to your daughter' Neighbours and relatives in the street noticed it. I felt sick.. We are in this society, we should dress like them . My mum said but you are an Asian , I said, Mum, but I am the same person no matter what I wear. I think it's respect, your mum and dad's name in the community. I felt that I would be letting them down but I wanted to be like the rest of them.My folks raised marriage with me when I was 18 but not any farther. I'm not typical. I met my husband when I went to America on holiday. Our arrangements were not typical. My parents were flexible though, maybe because my dad worked for so long on the buses."*

This woman was '*hurt* ' by the criticisms she received and felt '*at odds* ' with a number of people in the local community. She received strong support from her husband and sister and was active in a local community group, where it was clear many women held her in high regard, which she found supportive. She was determined to override the criticisms of her and what she was attempting to do, and was confident that she would win over her parents to what she was doing.

Other women in the non-depressed group told me that conflict over their role was sometimes present as a result of activities they had recently undertaken. One example was a Sikh woman who lived in Edinburgh and had just started working part-time in a community centre. She told me she was unhappy at being taken out of school aged 13. Having hoped to be a doctor. She was sometimes criticised for her activities by some of her in-laws as her community was *'very traditional when it came to women'.*

es1nd

"I work 8 hours a week but there are a number of restrictions. There are limitations to what I can do. I've been here (in the group) 3 years and it's the first interview I've had with a male. There are a lot of restrictions about meeting males. Its brilliant work I love it. In our culture the men say that women should stay at home, women are not allowed to have relationships with the opposite sex before and after marriage. I don't agree with that. It's not true anyway. The founder of Sikhism said that men and women were equal within the family.

"Careers don't exist." I asked why she was different in that she was working *"It's my personality also my husband is very supportive, it's his personality as well. If he wasn't so supportive, I couldn't do this. I look at my friends.... I hate to think what life would be like if I had been at home all the time. It would drive me up the wall. In the past there were large families, now it's different. There is less contact with other families.... women are more isolated now.*

I'm a member of this group obviously.. It's great for your morale... it means you get out, there are things to do.. Swimming, we go on trips which are quite a regular thing. It's a great achievement really.. first it was frowned upon. Now we all look forward to it, getting out and meeting other people. If you're not a member you'd be in the house most of the time."

The women had a very strong network of confidants and a very good social network. She got great fulfilment out of what she was doing. The support of her husband was clearly very important.

If we compare the experience of this woman with one of the depressed cases we see again how the source and strength of the conflict as well as support throughout highlight important differences between the depressed and non-depressed groups.

The case I refer to is a Muslim woman in Edinburgh, em2d**.** This woman's conflict over her role developed when her husband told her he wanted her and the children to move to Pakistan to live. The women had been there before and dreaded it. They had lived in a village which she found 'backward' and in which she felt 'alien'. She did not want to be a 'typical village woman' . This process made her think of what she actually wanted to do and it was clear that she found her husband's expectations of what her role should be incompatible with her own expectations of what she wanted to do. These events also made her regret not doing more at school.

em2d

"My parents wanted me to get married so they took me to Pakistan. I was 16. I felt terrible. Confused, rushed into it. I had no say, no feelings. I was almost tricked into going to Pakistan. My brother was getting married. I had an idea, my mother had hinted. They took advantage of my innocence that I was so young. My husband is from a small village in Pakistan. There was pressure to stay in Pakistan. I didn't like it there: it was really backward. I worked at home all day on the sewing machine. I kept thinking that given the chance I could go to college and have better opportunities. I liked it initially. It was new, a change and in the country. I enjoyed lighting the fires and collecting water from the well. But then they started to take advantage of me. Even when I was pregnant I was lifting

heavy things. My husband was out all the time. There was only one sister in the family, she was out in the fields so I had all the domestic work.

"I was very lonely. I was depressed, stressed out. .... It was dirty work, unclean, I hated it. My hands all came out in spots. I even got hepatitis. When the drought came we had to drink dirty water from the well. I wore dirty clothes because I only changed once a week. I didn't change every day as the people in the village would have thought 'who does she think she is, coming over from England and showing off all her clothes'. I felt like an alien there.

" We came back home and I was relieved and looking forward to being with people I know and love. We agreed that we would live with my family when he came over. Nobody said anything about living in Pakistan. I won't be in control of anything. A woman can't go out unless you are with your husband. His family said there was an agreement that I would live over there but I've told him there's no way I'm going back to the village. If we go back it will be to the city. I don't like certain aspects of our culture especially men making things up like 'you're only allowed to wear this kind of dress. Men are much more dominating. Women have no opinion and no rights and are treated like dirt. My husband is still like that to an extent. Upbringing is the main thing and it depends on the personality. I know I'll have to go back but I really don't want to. I'm used to giving my opinion and I say what I think. I know that if I go over I will have to be a different person, act and dress in a different way. I'm dreading it, but what can I do? My family will have nothing to do with me if I don't go over. None of them understand, that it isn't me. I hate that lifestyle"

This woman had no support throughout this crisis. She felt '*very isolated*'. In the following paragraphs I summarise the experience of role conflict in the non-depressed women, again to give a flavour of these experiences.

gh1nd- this woman explained that she would occasionally have arguments with her husband about her social life. She went part-time to evening classes and also keep fit classes. This meant finding baby sitters and the husband often complained about being left with the children. She felt he wanted her to curtail her out-of-the-house activities to be '*a good housewife*'. She was adamant this was not going to happen. The arguments did have a positive side, she said, because they '*cleared the air*'. The woman had very good support from her sister and close friend who had similar arguments with their husbands.

gh4nd- this women had a problem with the fact that her husband wanted to have more children and she was unsure as, although in principle she wanted more children, she also wanted to go to college part-time. She was unsure about what to do and did not feel comfortable about discussing this with her husband. He was not opposed to her going to college, but she was unsure about what his reaction would be. She was able to discuss this, however, with a close confidant. She said that if she did go to college she would be supported by a local community education group.

gm7nd- this woman was happy at the moment being a housewife and a mother but felt that it was not something she wanted to do indefinitely. She was unsure what she wanted to do in the future but was sure what she didn't want to do which was be an eternal housewife. She spoke of her friends one of whom was a self-employed beauty therapist, another at college and wanted to do '*something like that*'. She often spoke with her friends about this.

It is clear that there is a fundamental difference between the two groups of women both in terms of the strength and source of the conflict, the actual duration of the conflict, the outcome of the conflict and the support received throughout the conflict. There are other important differences that merit comment.

(i) Four of the women (**em3nd**, **gh1nd**, **gm8nd**, **es1nd**) in the non-depressed group experienced conflict because they were being criticised doing what they wanted to do. They were fulfilling their aspirations.Two of the women in the non-depressed group (**gm7nd**, **gm4nd**) had the opportunities to alter their roles but were unsure of what to do. This contrasts with those in the depressed category who were very unhappy in their present roles, unable to fulfil their desired roles and saw no way of achieving them or felt that they had missed out on what they could have achieved as a result of their past.

(ii) The non-depressed women all had good support. They had good confiding support and good social networks. This helped them in two ways: first by giving them an opportunity to talk about the conflict and second by giving them a route to fulfilling their desired roles. The depressed group, had no support and whereas with the non-depressed interviewees the people they spent most of their time with (i.e. husband and family or friends) were supportive, these people were often a major source of the conflict in the depressed group.

The following section looks at the second sub-group in the "Severe Events Involving Loss" category. This is category (b) and covers "Loss Through Specific Events".

(b) Loss Through Specific Events

This second sub-group in the loss category involves five interviewees who experienced loss through separate and specific events. These were: loss through death (2), loss through miscarriage, loss through separation and loss through family dispute. I shall address them individually.

Loss Through Death

A Glasgow Muslim woman, gm2d, became depressed following the death of her sister to whom she was '*very close*'. The death was sudden, had come as a major surprise and was a devastating blow to gm2d

gm2d

> *"I'm still trying to cope with the death of my sister. With the way things had been going, she was the only really close person I had, we used to see each other every day as she only lived up the street. She was the closest person I had and now she's gone there's a big gap.... I've never really been able to talk with my husband the way her and me used to talk. When things were difficult we could always laugh at things but now I can't... my husband, he works all day and night so we don't get the chance to talk..... ....we still have time to argue, though.'*

The woman's closeness to her sister meant that she could talk about problems which she found a big help as well as enjoying her company. It appeared that the woman was still grieving about her death seven months after the event. The woman had not spoken to anybody about it so was having to cope with the loss on her own. The woman's sister was her only confidant, a source of support, a crutch to lean on in difficult times and also, it would appear, her closest friend. To lose all of this and without any prior warning overburdened the woman with grief. That she had no outlet for this grief seemed to make the loss harder to cope with.

Loss Through Miscarriage

This involved a woman who became depressed following her most recent miscarriage. This miscarriage, an enormously stressful event in and of itself, was all the harder to cope with because of the woman's strong desire to have more children (she had one daughter).

gh3d

> *"After my daughter was born I wanted more children but I have had three miscarriages. I want more children. I was wanting two more, a boy and a girl. I feel a lot of pressure when I hear about other people having children..... I miss my mother , she lives in England and I miss my family. I used to live with my mother-in-law and had the miscarriages when I was there. We really didn't get on and I felt I didn't get the support I deserved. It it had been one of her daughters it would have been different. .... The future? I don't know , I don't really have plans I had my heart set on a big family but now that's not possible, I don't know."*

A number of factors emerge from this woman's experiences. Firstly, she has gone through the trauma of expecting a child then losing it, not once but three times. Secondly, she felt she lacked the support she needed from her mother-in-law and is missing her own mother greatly. Thirdly, her dream of a large family can no longer come to fruition and she does not know what to do with herself in the future: she is unsettled. These events have combined to undermine the woman's personal health and personal situation to the detriment of her mental health. Again, she is weak in confiding support and social network and this appears to have had a negative influence in light of her experiences.

Loss Through Separation

A similar picture emerged from my interview with a Glasgow Muslim woman, gm9d. This woman told me how her relationship with her husband was *'falling apart''*.

gm9d

> *"We are separating and it's really hard, I'm upset for my children, they don't know what is going on and are always asking for their father. It's really hard just now for them... I hope its not going to be too messy, things have been bad for a while, he was a part owner of this small restaurant in Edinburgh and spent most*

of his time there. It meant that I was alone with the children and that money was not always as much as we needed. It's been a disaster and looks as if it will have to close. We are going to lose money and I don't know how to cope'

Her situation was made worse by financial problems arising from the collapse of her husband's business in Edinburgh. The women has had three serious stresses to contend with over a significant period of time. A collapsing relationship with her husband and the uncertainty this meant for herself and her children, financial concerns both present and future and bringing up her children largely without the help of their father. The strain is now beginning to tell on her children which concerned her deeply. Her support is weak both in terms of confiding and social network.

Loss Through Family Dispute

One woman had had a recent fall out with members of her own family after hearing that her father had been having an affair with another woman whilst married to her mother. She had confronted him over it and had argued with other members of her family. This led to some of her family not speaking to her, and, being very much a family-orientated women, she was in distress over the whole situation.

gm10d

" It was so difficult, we used to be such a happy family, my brothers and sisters got on so well. But now we are split, the bond is no longer there, it's not the same now. I seemed to have reacted to it worst of all in my family. My mother has lost interest in her children- she sees me as an enemy. That's what the problem has been.

"I can't really go to anyone. Because the problem is between my parents and it is known between my in-laws, I can't turn to them to talk about it. I feel ashamed. I feel ashamed because of my parents- my father. .....Family is important- the

head of the family are your parents. They are seen as the pillars of the family, if one pillar is bad it disturbs the whole building. Because of the conflict the family has been scattered. When my brother got married it should have been a big occasion with all the relatives there. But when he got married it was done quietly.... it was over in about an hour.. usually the whole thing can take a week. My father didn't attend. That occasion hurt so much .... I'm the eldest, I hurt for my brother, maybe I worry about him too much." I asked her how important the family name and honour were. " *For me, very important, I certainly hold that view.*

The woman could see no way of overcoming her difficulties, although she told me during the interview that she had thought about moving to Pakistan to live. She was in a dilemma over this because her children were becoming settled in school in Glasgow and felt if she didn't go soon it would not be fair on her children to move back to Pakistan. She felt awkward about talking regularly to her husband about her own parents. All contact with previous confidants had been broken as had her social network which had previously been quite active.

The next section covers the two remaining categories, severe event without loss and on-going major difficulties.

(ii) Severe Event Without Loss

In their original 1978 study, Brown and Harris found that whilst most severe events involved loss, a fifth of patients who had a severe event did not have one involving loss. They felt it important to explore the apparent exceptions to the conclusions that loss was the central feature of events bringing about depression. These events included; (i) being attacked in the street (ii) moving to another area where she knew no-one (iii) an unplanned pregnancy (iv) a son's admission to a mental hospital for the first time for alcoholism. In my study, one woman fell into this category.

Sexual Harassment

This woman explained that on a recent trip to Pakistan she had been sexually harassed by a relative. In addition to finding the whole event deeply upsetting, the situation became worse when the mother of the harrasser claimed that she must have led the young man on. This led to an argument and the holiday ended abruptly and disastrously.

gm8d

> *"When I was abroad in Pakistan a relative made advances to me and sexually harassed me. .. It was my husband's youngest brother. He is young and immature... I didn't tell my husband but he kept asking me 'what's wrong' eventually I told his mother and she blamed it on me, she said that he would never do that and if he did I must have been leading him on, it was total rubbish. I felt very guilty about the whole thing and eventually told my husband. He said that he would never speak to his brother again and his family accused me of breaking up their family... it was terrible. He has relations over here and they know about what happened and I know they have said things about me. When I was younger I was a bit of a rebel so they think... you know... there's no smoke without fire."*

The woman was unable to discuss the problem with anyone. Although she was able to confide freely in her husband, she did not discuss this event with him as it caused both of them too much distress.

The final category in this section is on-going major difficulties. In addition to severe events, Brown and Harris also found that in a minority of cases a restricted class of difficulties - termed major difficulties- appeared to be of critical importance for depression. These have to have lasted at least two years (Brown and Harris, 1978). In a number of other studies, major difficulties have made an added contribution to risk of depression. Brown and Harris (1989) noted that although the process by

which major difficulties contribute to depression is less intuitively clear than the role of severe events, these major difficulties embody many similar features found in severe events: i.e. they are the same in terms of meaning, comprising aspects of disappointment and loss.

(iii) On-going Major Difficulties

There were six women who came under this category. With five of the interviewees the nature of their on-going difficulties was very similar in that they involved internal family disputes which had lasted for some time. Family disputes are often detrimental to mental well-being. For example, following their research into the effects of intrafamily conflict on depression, Kashani et al (1985) contend that there is strong evidence that dysfunctional patterns of intrafamilial conflict resolution may play a clinically significant role in depression. Studies have examined more directly the relative contribution of family-related stress to negative mental health outcomes (Kandel et al, 1985). Overall, women are especially vulnerable to the negative effects of family conflicts (Kessler et al, 1985).

Moos (1990), noted that family conflict heightens the likelihood of initial onset of depression, just as it increases the likelihood of relapse. Following his study on intrafamily conflict Strauss (1979) contended that a key factor differentiating what the public and many professionals regard as "high conflict families" is not the existence of conflict *per se*, but rather, inadequate or unsatisfactory modes of managing and resolving the conflicts which are inherent in the family. In addition, very high levels of intrafamily conflict can create such a high level of stress and/or such rapid change that group welfare is adversely affected.

The remaining on-going major difficulty involved a woman living in an overcrowded house with severe financial problems which she saw no prospect of being solved as her husband was unemployed. Their position was exacerbated by neighbours who were racially abusive. Their plight had lasted '*at least three years*'.

The first case of ongoing major difficulties involves a woman working in a business owned by her husband and brother-in-law and who had financial disagreements on the running of the business which became personal and involved other family members.

gs1d

"In the shop with the family there are a lot of pressures, working with your brother-in-law can create difficulties. My husband's brother always thought he was the boss although he only owned 25% of it. Things in the shop started to go wrong and that's when all the family problems started.

"I was close to his family but problems started when my sister-in-laws came to live with us. The problem was that we had a crisis in our business then things started to go wrong in our family relationships. They wanted too much money from the shop. We went to India and my husband's brothers family were trying to spoil things for us. They were talking behind our backs but we didn't find out till later. I argued with my brother-in-law's wife when we were struggling with the shop. I said to her to get a job on the side and use the money to get out and enjoy yourself more. They thought that we were trying to lock them out. We weren't but there were a lot of petty fights like that....this lasted for a couple of years. It wasn't fighting all the time but there were a lot of petty little things.

They were moving out of the house, my husband put the house up for sale. That's when they started talking about us. They were mixing things saying that we were kicking them out of the house. I didn't know I was depressed. I was losing weight and I couldn't sleep at night. When my mother-in-law died everybody would come to our house especially my sister-in-law. We were very close but she stopped talking, I don't know why. We needed a bigger house. I was very upset.....When I

look back I was too soft, I didn't know how to be tough. I look back and say 'how did I let him get away with that'.

"Two of his brothers stopped talking to me. I don't know why, a lot of things happened. Probably the thing with my brother-in-law. I felt the world had ended. There was a lot of gossip going around. My husband says 'forget about everything, get on with your life' but its hard when you are so down. The family can stress me out, I worry a lot about it.

The trauma described by gs1d had began over two years ago. She went through this trauma unsupported, both in terms of confiding and social network support. As she said herself in the interview *"I couldn't talk to my husband about it because he was suffering as well, although not as bad as me. I had no one, which made it worse. When I tried no one would listen."* The stress was daily. If there were no arguments then in the background was the possibility that one could happen at any time. The woman explained that her relationship with her husband was becoming difficult under these circumstances.

eh1d

"My husband works away from home all the time..... It means that I have to bring up the kids totally on my own. His family offer to help but I don't want their help.... because they take his side all the time. We had this big argument because I thought he was up to something... you know seeing another woman. He keeps telling me I'm off my head but I don't know about him. His family said that I was wrong and that I was being ungrateful because he was out all the time working and here was me giving him a hard time. They were telling <u>me</u> how I should talk to my husband. That was typical though... they try and interfere, his mum and sisters, telling me where my kids should go to school and all that. When they go out they always expect me to go with them.... when I don't I'm some kind of bad

person, they get their nose in at every excuse. Who needs that? I just find it too much at times I end up losing the head and shouting. I mean what I say , but after it I wish I'd kept my mouth shut."

eh1d had weak confiding relationship. There were no confidants regularly available with whom she could discuss her dilemma with. Her doubts about her husband were made more difficult by his family who, she felt, '*always took his side, no matter what'*. The pressures of her deteriorating relationship with her husband and his family were exacerbated by what she saw as '*interference*' in her own personal family life. This situation had lasted for '*over a year*' . There are important differences between this woman's experiences and those of gm1nd below.

I shall quote two other interviews from this category to highlight the nature of the intra-family conflicts in more detail.

gm3d

" I had fight with one of my cousins about my kids. My kids were getting hit at school by her kids so I went to the school to do something about it, but they were just hopeless. Then her family started giving me hassle. The woman sent her brother-in-law to fight my husband, she said that we had said things about her family. A lot of it stems from her because she has a sister that was interested in my husband. She's been hassling me. She's a real bitch. I said 'go to hell'. She's always looking for trouble. She started swearing at me in the street once. All the hassle is getting me down. It's got that bad I'm looking for a house in another area. This has been going on for three years. She's even been up at my door. She came up once with her sister. My kids are upset and for a while didn't want to go to school. I want to move and get them into another school, get away from this whole area. I've been to see the police and lawyers and its been useless. I went to my MP and he wrote a letter to the head of police about the harassment.

" I don't talk to anyone about it now. I don't even talk to my husband because he gets worried so I just keep it to myself. I don't even tell my parents now, my dad's not well he's got heart trouble and high blood pressure.....It makes me so down.... It would be better if I could talk to someone about it. I'm close with my uncle's wife but she's away a lot and since he died has not been very well so its difficult.....As I said I don't talk to anyone about it. People make things up so I don't tell anyone. I had a good friend I could talk to but she went to Pakistan. I could talk to husband about most things and would go to him if I had a problem.. My husband has his own problems though- he can't get a job it's ridiculous. I can't talk about the hassles with my husband, he gets upset My uncle died of a brain haemorrhage, people said it was all the stress, I don't want my husband worrying".

gh2d

"Before we got married I told him that I wanted the house to be just for the two of us, I didn't want what I saw was happening to my sisters who had relatives there all the time, sometimes staying for months. He agreed but then his brother came up from London and stayed with us for a while. He said it was just until he got settled but then he got married and they ended up staying with us. I should have known..... to tell you the truth I never liked his brother but I made an effort.. .....maybe not hard enough though. My husband told me that I never gave him a chance.

"Now he and my husband work together and they are really close. I can't win. We seem to argue all the time now and it means that me and my sister- in-law don't really get on. He says they will move out when they get enough money but I wonder. I can't stand it. I am a private person, I need time to myself but he doesn't

see it that way. Is it wrong that I am like this?... No ... but he seems to think so. If it keeps going like this I'll really crack up. They are talking about children... my God we've only got one but another in this house and it'll be like a madhouse."

The strength and impact of the family disputes with the depressed women were central features in their lives. The disputes in this group lasted on average at least two years, and in one case three years, the situation being so bad that the woman (gm3d) had involved the police, her M.P. and was trying to leave the area. In the case of gm10d she was thinking about leaving the country, the effect of her family dispute being so strong. The nature of the family disputes in this group militated against confiding because the persons they previously confided in were now involved in the family disputes and their relationships had deteriorated.

With the non-depressed group, the duration of the disputes was short and they occurred irregularly, the women referred to them occurring *'every few months'*, but in one case the last occurrence of the dispute was six months previously. The strength of the disputes was significantly weaker than among the depressed women. These women also had very good confiding relations, enabling them to talk about any problems that arose which helped ease their impact.

The women in the depressed group spoke about their family disputes as a central, very negative feature of their lives. They saw no obvious or easy way out of their dilemma, other than the rather drastic step of moving house or leaving the country. The non-depressed group of women referred to the family disputes as an occasional irritant and, in the case of gm6nd, as an irritant that would disappear when they moved house.

There are, therefore, significant differences in the strength, duration and impact of the family disputes when comparing the two groups of women. The other critical difference is that the depressed women had weak confiding relations (and a poorly developed social network preventing them from meeting potential confidantes) which militated against them coping with the disputes they found themselves involved in. As one of the depressed women commented, this made matters worse.

The remaining woman in this category explained her position after showing me around her house

(gm1d)

> *"We have lived like this for the past 3 or 4 years. The rooms are damp and we have to sleep with our children. My husband lost his job following his illness and is on medication.....We get by but at times it is very hard for me, not for me but for my children. ... There is a neighbour who calls us names and shouts at the children when they are playing. One day he threw a basin of water over them...The police never come, it is hopeless."*

Some Preliminary Conclusions.

In understanding the nature and influence of life events in this sample of second-generation South Asian women, their varied social experiences discussed in chapter 2, as well as the interview data reproduced in this chapter, have to be taken together, particularly when addressing and understanding the question of social roles and role conflict. As this chapter has attempted to show, Brown and Harris and Brown's insistence on taking account of the social and (following Brown's work in the Hebrides) cultural context as well as a person's biographical account of their circumstances is particularly relevant. In addition, Pearlin's comments on the importance of social roles helps us to understand the nature and impact of life events on depression among second-generation South Asian women. The notion of loss and disappointment were the central features of most events in second-generation South Asian women interviewed in this study. From the study it appears that social roles are implicated in life events among these women, in particular the loss of a valued goal or aspiration relating to a particular role which led to conflict over an existing role. With the role conflict category, the nature of loss was not uniform, although loss through role conflict was experienced, there were in my opinion four subtly different sub-groups in this category: loss of a cherished idea; loss of an aspiration concerning a cherished idea; reconfirmation of loss of a cherished idea; loss of a person and a cherished idea.

The first sub-group was loss of a cherished idea, related in this case to a career and employment and linked with this, a degree of independence. In the case of gm7d, em1d, es2d, gm11d the desire to work (they all had experience of working) and get fulfilment from work, as well as contribute financially to the family and not rely on one person, was strong. This was not possible; they could see no way it would become possible; and subsequently felt the loss of a cherished idea.

The second sub-group within the role conflict category who experienced loss involved aspiration concerning a cherished idea. With the women who had their sights set on further education, (eh2d, gm6d, em2d, es1d) the type of loss was associated with aspirations of themselves as professionals something they cherished. One other interviewee in this category was em2d who had wished to move nearer her own family and be with people she knew would support her, as well as relate to on a personal level. By moving to Pakistan this aspiration was lost.

The third category of loss in the role conflict section involved reconfirmation of loss of a cherished idea and involved gm5d, gh4d and gm4d. All her adult life gm4d had wanted to go to university, she felt the loss at being unable to go at the time, as well as the career associated with a university education (as she perceived it). On meeting her friend in the street she heard how her friends from school were doing, how they had professional jobs, lived in flats on their own, and travelled. This news reconfirmed to the woman her loss. Gm6d, ever since school had wanted to go to university. She was of the opinion that her family had thwarted this aspiration in favour of a more traditional role of mother and housewife. The woman still hoped to go in to full-time study, was of the opinion this was still possible but had been blocked despite her husband initially being prepared to co-operate. Again, we see the reconfirmation of loss of a cherished idea. With gh4d, the woman had wanted to marry her boyfriend, a white Scottish man, but had been forced to choose between him and her family and, from her point of view, having to leave him. She had lost her boyfriend. Although in the past, the loss was brought home to her again when told he had married, something the woman found very painful.

Another type of loss in the 'role conflict' category concerns the loss of a person and a cherished idea. Following her disputes with her husband and mother-in-law, gh1d had been unable to continue working, something with which she associated very favourably in terms of how she saw herself. Not only had she lost her job, she had also lost her husband as a result of the situation she found herself in.

What the women in the role conflict category have in common (apart from weak confiding relations) is that they had not only experienced loss but they found themselves in situations that were non-rewarding, deprived and/or boring and could see no way out of their predicament. They had an idea of themselves which had been lost through the event; or a past loss had been reconfirmed by an event and this loss appeared to negatively affect some part of their core identity.

As we saw in this chapter, role conflicts affected non-depressed individuals, the key issue here is the availability of confidant support, and, to a lesser extent, who the conflicts were with and the resolution of these conflicts in favour of the individual concerned.

Within the remaining loss category, loss through specific events is reasonably straight forward. Loss through death (gm2d, gs2d), separation (gm9d), and miscarriage (gh3d) are self explanatory, in that all involved the loss of a person. Loss through family dispute (gm10d) requires a brief comment. One may wonder why this was not in the on-going major difficulties section where intra-family conflict predominated. In that section the difficulties had been long lasting and none of the respondents seemed to wish to maintain contact with family members as this was the source of their difficulties. On the other hand, gm10d was a family oriented person who, following a family dispute, had lost contact with her own family who she loved. She felt an enormous sense of loss as a result of this. Once again, the availability of support is a key factor.

Two other categories of life event accounted for the remainder of the depressed sample. On-going major difficulties, taking the form in this study of intra-family conflicts (gs1d, eh1d, gm3d, gh2d) and chronic poverty, overcrowding and racism (gm1d) and, to a lesser extent, severe events of an acute

nature but not involving loss gm8d (in this study a case of sexual harassment), contributed to increasing the risk of depression where support (especially from an available confidant) was weak or absent.

The concept of loss in depression is on the basis of this small study applicable to second-generation South Asian women. The nature of loss varies and one would have to take into account some of the issues, particularly relating to acculturation and women's roles discussed in chapter 2, when addressing the question of loss in this section of society. As Brown and Prudo (1981) noted following their study in the Hebrides, the cultural context has to be taken into account.

The Acculturation Process and the Onset of Depression in Second Generation South Asian Women:A Personal Perspective following this Study

The process of acculturation, as I have outlined earlier, can under certain conditions increase the risk of mental illness in those individuals seeking to acculturate, regardless of the degree of acculturation. It is, however, not a global interpretation of risk. Not everyone who experiences stresses and strains as a result of the acculturation process will develop a mental illness. There are no fixed patterns, no direct causal links. Other factors, such as chronic disputes over family business details, the chronic strains of poverty and, importantly, the availability of confiding support, can and do influence the onset of mental illness.

The acculturative process can lead to acute and chronic stressful events where a person, who adapts or attempts to adapt practices and values of majority cultures faces conflict and criticisms from those in their immediate vicinity; husband, family (both their own and husband's), immediate community and often friends. In addition the same person comes under pressure from friends from majority cultures to adapt and change and thus feel equally pressured. Such individuals can feel marginalised, made to feel there is something badly wrong with them, and furthermore that they are letting their family and friends down. The outcome of this situation can vary. There are some who reach an accommodation, some who adopt their desired changes, but also some who experience conflicts that remain unresolved. Some women reluctantly decide against change but their consequent everyday

experiences re-enforces their unhappiness when they consider what they could have been doing. They feel a sense of loss, they have not secured or attempted to secure their goals and aspirations be it as a professional such as a doctor or pharmacist, or in running their own business. Instead, they are carrying out a role as mother/housewife which is completely unfulfilling. Their loss is therefore exacerbated in their daily lives. On occasion their loss is further exacerbated when they see friends or people they know carrying out roles that they themselves aspired to. The sense of loss can be acute or chronic or simultaneously acute and chronic. The sense of loss through their internal conflict increases their risk of depression and this is particularly so when they have no one to discuss their problems with and confide in. We know that the experience of loss is a risk factor in depression and that the risk is increased in the absence of confiding relationships. The acculturation process can therefore increase the risk of depression as it opens up avenues and opportunities that some women want to explore. The acculturation process can introduce alternative opportunities which some, not all, women find interesting. Their desire to explore these avenues or embrace these possibilities can and do vary. The desire may be merely to explore these avenues and, for the time being, change nothing, to partially embrace aspects of majority cultures following their exploration, to significantly embrace majority values and practices or to explore them and reject them completely. The central point is that all of the above experiences can, potentially, result in conflicts as outlined above.
To illustrate this phenonomen the experiences of gh6d, em1d, gh1d, eh2d, gm4d, merit re-examination and further comment.

The first interview quoted is a Glasgow Muslim woman (**gm6d**) who had hoped to go to university but her parents had wanted her to leave school at 16. She had maintained her desire to go to college and obtain qualifications for further education but this also conflicted with her husband's views of her role as wife and parent.

> *I am a predictable housewife. I tried to talk my husband into spending more time at home so I could go to college, but it always ended up in a big argument. My guidance teacher at school told me I could be anything I wanted. I could go into English, Art, Science. I think I could have. They all still interest me. That period of my life is still strong with me It makes me feel bitter*

angry. I look at my father's friends daughters and they are doctors and pharmacists. Those were my dreams and I suppose still are..... I really thought I was going to go to college, he (the husband) *did agree to it a few months ago then we had a fight and he changed his mind. His family even started having a go at me, saying I should be at home with the children....Don't get me wrong I love my children but I have a life as well.... I don't know if I'll ever make it now"*

The next woman is an Edinburgh Muslim (em1d) who had been in dispute with her husband over her wish to hire a childminder to look after their children while she went out to work. She was also very conscious of not being able, or willing, to meet the requirements of a 'good housewife'.

em1d

"When I got married I thought this was the person for me. But I became a second-class citizen, his family were number one. Part of the problem was that I didn't know all the cultural things like how to act towards my brother-in-law. My husband expected me to act in a certain way.... he had come over from Saudi Arabia and it was his first time in a country like Britain. I tried to go back to work and I did for about 6 weeks. We got a child-minder in. But my husband said 'no more childminder: only mothers can look after their children'.... I gave up working, I was really upset about that..... work gave me a sense of satisfaction, a sense of achievement, it gave me time off from the baby. .....I look back at how it was in the past and compare it to now..now it is nothing."

The next interviewee is a Glasgow Hindu who was in dispute with her husband and mother-in-law over her behaviour not meeting their expressed wishes.

gh1d

"Me and my husband had a really loveable, good relationship I could talk to him, was close to him. But it started to go all wrong when his mother came over from India. Her husband died and she wanted to come and stay for good. She didn't respect any privacy, she wanted to dominate all the time, she'd always done it in India I think it was her personality, she was a really mean person. She started interfering all the time One time she went through my handbag. She found the pill (birth control pill) and asked my sister-in-law what they were. She was annoyed when she found out. Then I knew the times that she had been in my room looking for things. Things were bad almost as soon as she arrived .... with all the interfering my husband started going out all the time. I couldn't take it any more, my husband was never in, he started to go out all the time.

"He says I'm too westernised that's why she doesn't like me- I'm too outspoken as well. I've worked all my life with Scottish people and have many Scottish friends. If they invite me to parties and that, I go although I don't go to pubs. He minded me drinking in front of his mum because an Indian women shouldn't drink or smoke or go out with friends. I love going out with Indian and Scottish friends. With Scottish people you are so open-minded and joke about anything. I'm Asian but I've never had any problems with my Scottish friends. I invite them over to the house for a curry quite a lot, I have some wine, it's a good laugh.

"Indian people keep themselves to themselves. When I meet them they want to talk about clothes and jewellery they are not as open and you don't get as good a laugh. Asian women don't go out as much especially those staying with their mother-in-law. Every time they want to go out they need her permission. I don't think that's right. Once you're married that should be it. I'm just a human being, I don't feel Indian though I pray to our gods, cook Indian food and dress in Indian clothes a lot.....I think I'm different from Indian women in that I drink a wee bit wine and go out, I'm more open. But I am Indian. He's blaming my Scottish friends for me being so outspoken and going out... He and his mum think I should be a certain person. It has gone downhill completely now, my husband has left and taken his mother with him, thank God,.....I think why?. Why can't he accept who I am?"

The next interview quoted is from an Edinburgh Hindu woman who wanted to set up her own business with a friend. This resulted in repeated arguments with her husband.

eh2d

"My friend and I have talked about setting up our own business in the line of health and beauty care.... she knows a lot about beauty and I know a lot about aroma therapy and massage. It is something I have thought about for years ever since I started going to some classes. She has already got the go ahead from the bank but is waiting for me. The problem is my husband is dead against it. He thinks I should wait until the children have grown up..... They are only young, why should I wait? It's something I've always wanted to do but he cannot accept that you can have a family and a life outside your family. I've told my friend to go ahead without me, I can't keep her waiting for ever. So now I'm left to do the normal thing..... sometimes the boredom drives me up the wall. Our relationship has suffered."

The final interview in this selection is with a Glasgow Muslim woman (gm4d) who had the qualifications to go to university but who became pregnant, against her own personal wishes and was now house bound with a child to look after, frequently visited by in-laws she did not get along with.

gm4d

"I have always wanted to go to university. When I was at school two of my Asian friends .. (Muslims with Pakistani parents) were going to university and two other friends who were white were also going to go. Two were wanting to study medicine, one law and the other pharmacy. I wanted to do pharmacy or medicine. I did well at school although I had a huge fight with my dad about staying on when I was 16. It got so bad that I ran away. It was only for one night but it was a big deal. I told him that I would leave for good if I wasn't allowed to

stay at school. I told a teacher at school and she came round to talk to my mum and dad. After that things were alright but an agreement was made that if someone was found for me to get married, I would get married.....Surprise, surprise, they found someone. I should have known.

"He was a typical guy, he was from Glasgow but he had strong views about me being his wife..like my father, I thought..... He is okay, he runs a shop his father owns and is really busy so I never see him. Only at morning and night when I prepare food for him. We talked about me going to university and at first I thought he would be in favour but he spoke to his family and said we should start a family. I was not wanting to. We fought. His parents spoke to me so did mine, I was being selfish, only interested for myself... I told them if I went I would get a good job and bring in more money. Nothing changed.....When I found out I was pregnant it was the worst day of my life. I had taken things the morning after and had visited the doctor about taking the pill, but if anyone found out I would be in big trouble. I was too scared so ....I ended up pregnant. I love my child, but I wanted children much later. Now I meet his sisters and in-laws, it's so boring. I don't keep in touch with my school friends. He (husband) doesn't like me seeing them but I would feel worse knowing what they are doing with their lives. None of them are married. I bumped into one of my friend's sisters in the street, she told me what she (her friend) was doing. She was at university, had a flat, had a boyfriend, went on holiday. I looked at myself and said "my God". "

This selection of interviews is a reasonable representation of the women in the who experienced severe role conflicts. These are woman with very specific and in most cases deeply held aspirations but have found them blocked. This process has in itself often resulted in conflicts with parents/ husbands and/or in-laws. The women find themselves in positions they dislike, performing tasks and duties they dislike and which are significantly removed from their own personal goals, values and aspirations. The woman above, like the rest of the depressed women in this category, has weak or very weak support and therefore bears these conflicts on her own.

As discussed previously there are women who experienced role conflicts and did not become depressed. Once again, although the experience of role conflicts can be a significant predictor of risk of depression, it is by no means a global interpretation of risk. As I shall demonstrate this is an important factor because there were women in the non-depressed group who experienced role conflicts, but who had support throughout the experience which turned out to be a crucial difference.

Those who came through role conflict- gm8nd, es1nd.

The Muslim woman in the non-depressed category (gm8nd) was experiencing conflict over her desire to be a police woman. She was currently working as a 'police special', a voluntary post which entails working (in the company of a police man/woman) as a police officer, with police powers. There was great talk of this where she lived, a predominantly Asian area, and most of the talk was not favourable. She was receiving criticism from local people and her parents were constantly being asked 'what she was up to'. She told me about the 'shock' some people had been in when she went out jogging in the park as part of her training.

gm8nd

> *"Since I started working I speak out more, I'm less shy and have more confidence. At school I was more Asian than Scottish. Since working its the other way around. Work is important to me, a housewife's life is boring. I want a career. I know other Asian women who want to have careers but can't because they have been married off. When I started working I used to dress traditionally, then I got this job and my boss said to me ' why are you wearing leggings under your skirt, what's the point' She was really rude- racist. So to mix with the rest of the work I dressed in Scottish clothes. But people started stopping my mum in the street and saying 'what's happened to your daughter' Neighbours and relatives in the street noticed it. I felt sick.. We are in this society, we should dress like them . My mum said but you are an Asian , I said, Mum, but I am the same person no matter what I wear. I think it's respect, your mum and dad's name in the community. I felt that I would be letting them down but I wanted to be like*

the rest of them.My folks raised marriage with me when I was 18 but not any farther. I'm not typical. I met my husband when I went to America on holiday. Our arrangements were not typical. My parents were flexible though, maybe because my dad worked for so long on the buses."

This woman was '*hurt* ' by the criticisms she received and felt '*at odds* ' with a number of people in the local community. She received strong support from her husband and sister and was active in a local community group, where it was clear many women held her in high regard, which she found supportive. She was determined to override the criticisms of her and what she was attempting to do, and was confident that she would win over her parents to what she was doing.

Other women in the non-depressed group told me that conflict over their role was sometimes present as a result of activities they had recently undertaken. One example was a Sikh woman who lived in Edinburgh and had just started working part-time in a community centre. She told me she was unhappy at being taken out of school aged 13. Having hoped to be a doctor. She was sometimes criticised for her activities by some of her in-laws as her community was '*very traditional when it came to women'.*

es1nd

"I work 8 hours a week but there are a number of restrictions. There are limitations to what I can do. I've been here (in the group) 3 years and it's the first interview I've had with a male. There are a lot of restrictions about meeting males. In our culture the men say that women should stay at home, women are not allowed to have relationships with the opposite sex before and after marriage. I don't agree with that. It's not true anyway. The founder of Sikhism said that men and women were equal within the family.

"Careers don't exist. I look at my friends.... I hate to think what life would be like if I had been at home all the time. It would drive me up the wall. In the past there were large families, now it's different. There is less contact with other families.... women are more isolated now.

Both women had a very strong network of confidants and a very good social network. important.

In this study, the onset of depression was not solely dependent on experiencing acculturative stresses. It is not always those who sought change and a moved towards values and practices associated with the majority cultures who become depressed. Likewise, not everyone who encompassed change and adopted such values and approaches become mentally ill. Variation and complexity of experience among Second Generation South Asian women was a central feature in this study, that includes the pro-change and no-change individuals. The importance of events both daily and long-term, of women's value systems, aspirations and their outcomes, as described by a woman themselves, along-side their levels of social support are in my opinion the central features in understanding depression in Scotland's South Asian community.

A Concluding Comment on The Acculturation Process and Depression

We can see from the diverse experiences of the women in this survey that the acculturation process is not a global interpretation of risk when assessing mental illness in ethnic minorities. Furthermore, not everyone who experiences stresses and strains as a result of the acculturation process will develop a mental illness. There are no fixed patterns, no direct causal links. Other factors, including social support, can and do influence the onset of mental illness. As this study hopefully demonstrates, mental illness in Scotland's South Asian community is not solely dependent on experiencing acculturative stresses. It is not always those who sought change and a moved towards values and practices associated with the majority cultures who become depressed. Likewise, not everyone who encompassed change and adopted such values and approaches become mentally ill. Variation and complexity of experience among Second Generation South Asian women was a central feature in this study,

that includes the pro-change and no-change individuals. The importance of events both daily and long-term, of women's value systems, aspirations and their outcomes, as described by a woman themselves, along-side their levels of social support are in my opinion the central features in understanding depression in Scotland's South Asian community.

As for the other two categories in the depressed group, severe events without loss and on-going major difficulties conspired (in the absence of social support) to have a negative impact on the women's mental health in that they led to depression, as has been found in a range of studies by Brown and Harris and other studies adopting their approach.

Chapter 5: Social Support and Depression

Section 1:A Review of the Literature

Section 2:Data Analysis

Section 1

This section examines the theoretical links between social support, in particular confiding relations, and its association with the onset of depression in women who experience severe event (provoking agents) or major difficulties. It examines the contentious issues surrounding social support, and looks at the arguments on the most effective ways of assessing and measuring this phenomenon. In doing so it provides the backdrop to the emphasis on confiding relations and their assessment in my study. The findings on confiding from the present study are presented and discussed. These findings are then compared with those found in other studies on social support/depression involving white indigenous women. I highlight some of the differences between the findings of these studies and arising from this research project.

Introduction

The influence of social support on psychological well-being has received considerable research attention. Studies employing a variety of theoretical and methodological approaches have consistently found a direct relationship between social support and psychological well-being. Much of the interest in social support is associated with the hypothesis that it may represent a buffer or mediator to the effects of life stress (Dohrenwend and Dohrenwend (1978), and substantial evidence consistent with this (buffer) hypothesis has now been assembled (Brown and Harris, 1978; Dean and Lin, 1977; Cassel and Kaplan,1972). However, the view that social support may be important for mental health independent of stress level (the direct-effect model), has also been persuasively argued and widely supported (Aneshensel and Stone, 1982).

Social Support and Depression

The link between stressful life events, weak social support and increased risk of onset of depression has been established in a wide range of studies. In particular, research into the role of severe life events (provoking agents) and/or major difficulties in the onset of depression among women has suggested that certain vulnerability factors can increase the risk of a depressive disorder in the face of such events (Champion, 1990). Considerable attention has

been paid to the role of vulnerability in depression. Brown (1989a) states that "*vulnerability may be defined as any characteristic of a person, or an environment that increases risk only in the presence of a provoking agent* "(Brown, 1989a: 28).

Following their original Camberwell study Brown and Harris carried out a number of other studies on depression and concluded that lack of a confiding relationship in husband or lover was much the most important vulnerability factor and was critical in understanding social processes associated with the development of depression in women. Brown (1989a) notes that the findings on confiding and the part it plays in depression among women have been replicated in a number of studies conducted by other researchers: Campbell et al (1983), Brown and Prudo (1981), Bebbington et al (1984), Parry and Shapiro (1986), Brown and Andrews (1985).

In a study on depression in first and second-generation Greek-Canadians, Berry and Sands (1993) found that second-generation Greek-Canadians experienced more stressful life events than the first generation and that these stressful life events correlated with marginality and depression in both generations. They also found that strong stable social supports, especially at times of stress, prevented depression. In relation to social support, Berry and Sands reported that strong friendships in the second-generation buffered the experience of marginality or general isolation and alienation. "*That is, having a peer to confide in and depend on in difficult times may bind a person to others, to their culture, and/or to the society in which the person lives*" (Berry and Sands, 1993). In another study which looked at social support, Berry et al noted that social support variables are found to mediate the acculturation and stress relationship (Berry et al., 1993)

What is Meant by Social Support?

The concept of social support has been variously addressed in terms of social bonds (Henderson,1980), social networks (Mueller,1980), meaningful social contact (Cassel, 1976), availability of confidants (Brown and Harris, 1978; Miller and Ingham, 1976) and human companionship (Lynch, 1977). As Turner et al (1983) point out, whilst these concepts are not identical, they share a focus upon the significance of human relationships.

In 1960, Ewalt observed that in relation to mental health social support appeared to mean many things to many people. Turner et al (1983) claim there is little agreement about the concept of social support, and that the concept has been interpreted in several ways and includes a range of phenomena. Despite this diversity of definitions, most focus upon the helping elements and processes of the social relation systems in which the individual is located (Gore, 1980). Thus, Gottlieb (1981) refers to the substance of social support as "*the help that helpers extend*", and Lin et al (1979) define it as "*support accessible to an individual through social ties to other individuals, groups and the larger community*". In the same vein, Pearlin et al (1981) describe social support as "*access to and use of individuals, groups or organisations in dealing with life's vicissitudes*", and Johnson and Sarason (1979) refer to "*the degree to which individuals have access to social resources, in the form of relationships, on which they can rely*". Cassel (1974) did not explicitly define social support, but he did point out that social support is provided by primary groups most important to the individual. This is consistent with the emphasis of Lin (1986) on the importance of binding relationships among confidant partners and House (1981) who suggested that social support be examined in the context of "*who gives what to whom regarding which problems*?"

There are several different subdivisions among types of support described in the social support literature. Of these the most consistent is that between emotional (affective) and practical (instrumental) support (Stansfield and Marmot 1992). Following their extensive review of social support theories, McColl and Skinner (1988) state that social support theory has three

main perspectives: the social network approach, the social integration approach, and the social psychological approach.

(a) The social network approach, looks at size of the network and several quantitative parameters of social contacts. This includes membership of groups and organisations, social contacts and family contacts. Mueller (1980) highlights evidence to indicate that variable types of social networks and interpersonal contacts are associated with psychological well-being.

An emphasis on social network has been criticisedon several counts. First it assumes that having relationships means having support (Schaeffer et al, 1981). Second, social network utilisation is not seen as equivalent to social support unless the quality of an interpersonal relationship is perceived to be satisfactory. This view is based on the premise that simply having many people around one with whom one interacts frequently, may or may not be supportive (Vega, 1991; Pearlin et al., 1981; Valle and Bensussen, 1985). Thirdly, it often fails to take into account the possibility that some ties may be detrimental or counter-supportive. Some ties with friends and families are sources of stress and conflict rather than support (Hall and Wellman,1985). Further, the network approach assumes that the various aspects of the network are part of a single dimension that can be added to give a meaningful score (Hall and Wellman, 1985). Pearlin et al (1981) suggest that being embedded in a network is only the first step toward having access to support. The final step depends on the quality of the relations one is able to find within networks.

(b) The social integration, which considers the extent to which individuals feel they have access to a number of human resources.

The social integration approach involves the extent to which subjects are embedded in a social network or surrounded by others who might offer support. This approach is criticised for assessing potential rather than actual support (McColl and Skinner, 1988). In other words, it records the availability of a network of supportive contacts, but does not examine whether or

not these supports could be used in a stressful situation. Measures of social integration are also criticised for overlooking the subject's perception of relationships as supportive or otherwise. As an example, it is possible to imagine a situation where an individual feels embedded in a large and seemingly active support network, but does not feel supported, and in fact does not have access to the necessary supports in times of stress (McColl and Skinner, 1988).

(c) The social psychological approach, evaluates positive affect related to social support. Implicit in considerations of this approach is an emphasis on social bonds (Henderson,1980), meaningful social contact (Cassel,1976), and confidants (Brown and Harris, 1978). Behind this approach is the view that these address a core human requirement, namely, the perception of being supported by others close to oneself.

A confiding relationship, in which people can talk intimately about themselves or their problems, has been shown to be important for good psychological health status in several studies. Brown et al (1975) examined the influence of a confidant in reducing the risk of depression in women following a major life event or long term difficulty. Among those women who lacked a confiding relationship with a husband or boyfriend, 38% developed depression following life stress or major difficulties, compared with only 4% of women with such a confiding relationship. Similarly, Lowenthal and Haven (1968), Roy (1978) and Miller and Ingham (1976) have reported that the availability of a confidant has beneficial effects on mental health in times of stress. Dean et al (1980) found that lack of companionship support showed the strongest association with depression in all age groups.

Buckley (1986) is critical of the emphasis laid on confiding, particularly in depression studies where she warns that lack or perceived inadequacy of confiding relationships may be a feature of the depressed subject's perception. Buckley (1986), states there is a need for clarity as to what counts as confiding and believes it is not enough merely to establish whether someone has anyone with whom they can discuss worries or problems. Frequency of contact and whether the confiding relationship is reciprocal are also important.

Measurement in this Study

Although addressed in Chapter 3, I shall recount what the women were asked with regard to their confiding relationships. In this study the women were asked

(a) Among your friends and family do you have anyone with whom you feel you can share your innermost thoughts, feelings and problems?

(b) If not - have you ever had anyone? If yes, what happened, why can't you confide in them now?

(b) If yes who are they, do you have more than one, name the others and your relationship to them (If they do not mention husband, probe, if not why not?)

(c) How often do you see the confidant/confidants?

(d) How do you feel about the frequency of seeing them.

(d) What does it mean to you to have these people, what issues do you discuss.?

This was seen as a generalised measurement and their replies were marked as follows;

Assessing Strength of Confiding Ties

'a'- Strong, one or more confidants available and seen at least once per week.

'b' - Moderate, one or more confidants available and seen approximately every month.

'c' - Weak, one or more confidants available and seen approximately every three months.

'd' Very weak, no confiding relationship.

Section 2

The following section provides an analysis of the strength of confiding relationships in my sample of interviewees.

Data Analysis : Strength of Confiding Relationships in Depressed and Non-depressed Interviewees

The depressed group were clustered in three main categories. The largest category was Category 'd' (Very weak confiding relationships) and contained 10 out of 23 depressed interviewees. This was followed by Category 'c' (Weak confiding relationships) which contained 9 out of 23 depressed interviewees. The next category, Category 'b' (Moderate confiding relationships) had 3 out of 23 depressed interviewees. There was 1 person in the depressed group who came under category 'a' (Strong confiding relationships).

The non-depressed group were concentrated in two categories of confiding relationship. The largest was Category 'a' (Strong confiding relationships) with 16 out of 23 non-depressed interviewees. The second category was Category 'b' (Moderate confiding relationships) with 7 out of 23 non-depressed interviewees.

Group 1 : Confiding Relationships in Depressed Interviewees

Category 'd' Very weak (10 out of 23 interviews)

This category represented those women who stated they had no confidants. Out of the ten women in this group six stated that in the past, the shortest period being at least 6 months, they did have individuals they could confide in but that they could no longer do so with these same people. Two of the five could and used to confide in their sisters but following personal disputes no longer did. One woman could, and used to, confide in her sister-in-law but following a family dispute was no longer in contact. One woman confided in a close friend who later made public what the woman thought had been confidential. The relationship was terminated. One woman stated that her only confidant died over a year ago. Another woman

could confide in her sister but she had been very ill for some time ('at least 6 months') and she felt it was not right or possible to confide in her. The other four women stated they had no one they could confide in. The following extracts are typical examples of what was stated by the women in this category.

gm5d

"There is nobody an Asian woman can talk to... because they're too scared. I feel down about things, I think I could have done that and I didn't do anything about that. There is a big gap in my life where all I did was sit in the house from the age of 13 to 18 years. If you talk family pride is at stake... oh my God, that's so important to Asians! So people don't talk about their problems. I went to that group that was set up for Asian women. My mother died and I was under a lot of stress. .... The counsellors were a waste of time, it was as if the Asian females.... they were worse off than me. It was as if we were still in Pakistan, my mind wasn't in tune with them. They were unaware of my problems. I wanted to scream, I wanted to let my feelings go, to be a real bitch. They should hear the aggressive things I want to say. I had to act in a certain way, I couldn't let it out.

gs1d

"At the time my sister-in-law was closest to me but that began to change with the family hassles. I couldn't talk to my husband because he was suffering as well although not as bad as me. I had no one, which made it worse. When I tried no one would listen. I used to be able to talk to my mother-in-law before she died. Nothing went wrong when she was there. I eventually said 'look I want to talk to someone'. Part of the problem is- if the problem had been outside, she and the family could have helped but they were the problem!

gh1d

"My family are in Dundee. I'm very close to my sister; she's the one I go to most but with her being in Dundee it's not so easy. She has her own problems as I've said. She's very ill and I don't like hassling her with mine all the time.

Category 'c' Weak (9 out of 23 interviews)

Although confidants were identified by the women in this group, there were major access problems which meant that they saw the confidant/s very irregularly, approximately every three to four months. This was found to affect the confiding, in that time would have to pass before the individuals felt confident enough to confide. Also, the fact that they were apart from these confidants for some time meant that often when they saw the confidants, the problem/difficulty giving them most concern had developed to such an extent that either they did not know where to start or that confiding was not going to solve the problem as it had grown so large.

gm6d

" I can talk to my husband in a number of things but not what concerns me most. I had real problems with my parents when I grew up and I can't make my husband understand what went on with me when I was between 16 and 24. I can't make my husband understand why bringing up my daughters must be different. I can also confide in my younger sister but she is ill and that makes it difficult.

em1d

"I have no one close I could do that with (confide in). *I have friends but none really close...I talk to people about different things but I have no close person in particular* (I asked not even her husband) - *I wish it was my husband, but it's not the case..... I can't confide in my husband. I would like that - it's just not the case. Is it ever the case? I don't confide in my mother, she's a worrier. Since I've grown up I can't confide in my dad. We used to be close and I used to talk to him about a lot of things, but not any more."*

em2d

I can't confide in my husband. He doesn't understand me. I can't relate to him. I've no close friends here. I've no one to turn to. I can confide in my mother but she lives in Birmingham.. I see her about 3 or 4 times a year, it's good but it would be better if it was more often. He doesn't like me doing it though, he wants to keep me with him and his family. (The women then went on to discuss at length how her husband "*kept his eye on*" her).

Category 'd' Moderate (3 out of 23 women)

The three women classified as moderate in this group all had confidants whom they saw approximately every month but there were problems associated with the confiding in each case. An example is gm10d, who could confide in her husband but felt she could not really do so fully over her chief concern which was her dispute with her parents' about which she was very ashamed, and believed it was not appropriate to involve her husband as it was her own family.

gm10d

"My husband's helped a great deal. He's the only person I go to.... If not for him I don't know what would have happened. Sometimes in Asian tradition it..... I feel what does my husband think though..... they are my parents..... I'm a part of my parents. Other confidants... none. My brothers and sisters are not sympathetic towards me. They say we've suffered why are you going to doctors and psychiatrists (I probed here)....*they don't like the idea of me talking about them to someone else.* (I asked why this was a problem, was this the reason she only spoke to her husband?)

People talk about it- they gossip- I've heard from other people about my parents- that's why I've stopped meeting people. It upsets me. I asked about her friends ..*I have close friends but don't see them..... They are in England or Pakistan. I have friends but don't*

see them any more.... I write to my close ones in Pakistan but I don't know if they know about my parents."

"Not that I'm against my own community, but I know it happens. That is why I'm silent about my problem.....I was talking to someone once and they started telling me about another person's problems.... I felt terrible, these things should be confidential. If you live in a community like this you have to be part of it, even if you don't want to..... you get pin-pointed..... that makes it more difficult."

eh2d

I see my sister every two to three weeks and she has always been someone I can talk to about any problem, no matter how deep.....It can be a bit awkward though as all the other family are there and so we can't really have the time to ourselves we need.

gs2d

I can and do speak about these things with my sister but my mother-in-law lives with me and goes with me everywhere. I get very little time on my own to speak truly and freely without worrying what she'll think.

Category 'a' Strong (1 out of 10 interviewees)

The woman in this group appear to contradict the trend of the other three categories in that she had strong confiding relationships which were available on at least a weekly basis.

gm8d

I can usually talk to my husband about anything, but not this. It was humiliating, made worse by the fact it involved someone from his family. It is very hard to talk about it.....we had an argument about his family so I just don't discuss it.

The following extracts are typical comments from those in the non-depressed category. There were two categories in this group; strong confiding relationships and moderate confiding relationships.

Group 2 : Confiding Relationships in Non-depressed Interviewees.

Category 'a' (16 out of 23 women)

The women in this category had strong confiding relationships with at least one, and often more, confidants who were available and they saw at least weekly, often daily.

em3nd (Interview 3)

" I have close friends who I talk to from..... both sides but my closest friends are Asian. I'm lucky I've got some really close friends. I have a really good friend who I've known for 8-9 years, she lives in Edinburgh and we see one another every week. I'd share my personal problems with her. Some things I'd only tell my husband though... Its difficult to be specific....." I asked how important it was to do this and was told *"very important"* and we spoke about talking about problems *"A lot of people are frightened to go to a therapist because what they say may be passed on. People are really careful about what they say. I know I am. It's a small world, something got back to me once.. no-one mentioned any names but I knew who it was .. I find that disturbing.. that's why I'm wary. Some Asian friends I'd never tell anything* (I asked why) *because it would be all over the community. "*

em1nd

Stated she would go to her husband with personal problems or her sisters. I asked what type of things *"things personal to me..... I always have someone to turn to when needed. I am close with my sisters all of whom lived in Edinburgh. Me and my closest friends come meet once week..... If I have a problem I save it up for a Wednesday."*

es1nd

If I have a personal problem I can go and talk about it with my husband. He is a very helpful and understanding man..... I've got 2-3 good friends... one who I'm really close to who I've known for 18 years. I have one good Scottish friend. I have people that I can trust, not just my husband.

gh2nd

I have a number of good friends, some very close and I am close with my sister. I have one really good friend who I am close to who is Asian and I'm very close to my aunt. I can confide in them but it depends with my friend. If it involves my family I'd maybe leave her out of it. I don't confide in my husband a lot, it depends. If it is something to do with my immediate family I go to my husband. If it's just to do with me, I go to my friend.

Category 'b' Moderate (7 out of 23 interviews)

The difference between this category and category 'a' was in the frequency of contact with confidants.

gh3nd

I need to speak with someone quite a lot and when I do, it's good. That is what it's like with my cousin but I don't see her that much.....I don't know, about every month. When we meet I think both of us feel better.

gm6nd

> *I speak very freely with my sister but we don't do it as much as we should. I work very hard. I've three jobs and also the kids. We do make the effort to meet but something always comes up.....I'd say we meet about once a month on our own.*

What Does this Data Indicate?

When we observe the depressed and non-depressed groups we see a clear trend emerging; depressed interviewees on the whole have very weak or weak confiding relations and the non-depressed group on the whole have strong confiding relations but some also have moderate confiding relationships. On the surface this lends support to the theory of Brown and Harris that women who experience severe events (provoking agents) or major difficulties and have weak confiding relations will be at greater risk of developing depression.

If we look in more detail at some of the non-depressed women we see the value of strong confiding relations, the experience of **em3nd** being a case in point. This woman experienced many of the severe events that women in the depressed category faced, yet emerged without experiencing a depressive illness either during her crisis or in the aftermath of it. One reason for this may have been a change of heart on her parents' part in accepting her desire for a 'love marriage' instead of an arranged marriage, but the fact that she had "*very close friends who were available throughout what went on, as well as a future husband I could regularly talk to*" was of particular importance.

When we compare her experiences to those of **em1d** or **gm7d,** we see that although their experiences over marriage and upbringing were similar, none of these two women had the support or have the support to buffer the stressful events and so became depressed.

We can see the impact of a confiding relationship collapsing in the face of a severe event or major difficulty by looking at the case of **gs1d**. This woman became embroiled in a family dispute involving a number of in-laws. The dispute was very stressful for the woman but was

exacerbated by the fact that her only confidant (her sister-in-law) was involved in the dispute and their relationship broke down. As the woman stated *"part of the problem is had the problem had been outside the family she and the family could have helped but they were the problem!"* The woman eventually made arrangements through her GP to meet a psychiatrist, stating *"I eventually said...'look I want to talk to someone'.*

Some Apparent Contradictions

This could be a modified form of what Brown refers to when a confidant 'lets down' the person who expects to be supported, i.e. support from the confidant is not forthcoming. In the case of **gm8d**, **gm10d**, **gm6d** although they named their husbands as confidants, they were unable to confide in them on the severe events troubling them most. In the case of **gm8d** because of the nature of the severe event (sexual harassment) and the fact that it involved his brother and his family she felt very diffident about confiding in him on the topic. It exacerbated the negative feelings when she spoke to him about it and she did not, therefore, discuss it with him. She did not discuss it with anyone else for two reasons: she had no one else really close she could trust and she didn't want what had happened to her discussed in the community.

gm10d felt enormous shame over her father's infidelity and its impact on her family's relations and standing in the community. Although able to confide in her husband she felt 'guilty' about it. It was, she said, her family and why should she burden her already over- stressed husband? She was unable to confide in her family, particularly her sister who used to be a confidant, because they had feuded over what had happened. She refused even to mention it to anyone else for fear of 'gossip'. Again, we see how the actual severe event that was troubling her made it difficult if not impossible to confide in anyone else, thus increasing the effect of the event on her.

Factors Affecting Strength of Confiding Relationships in this Study

As already noted, Brown and Harris (1978) were influenced by Weiss (1969) and his views on intimate (confiding) relationships where trust, effective understanding and ready access were crucial if such a relationship were to develop. This was also the case with South Asian women in this study.

Trust

The importance of trust emerged in nearly all the women interviewed. The importance of trusting the person not to divulge what had been confided was of fundamental importance as can be seen by the following comments;

gm10d

> *People talk about it- they gossip- I've heard from other people about my parents- that's why I've stopped talking to people.*

em3nd

> *A lot of people are frightened to go to a therapist because what they say may be passed on. People are really careful about what they say. I know I am. It's a small world. Something got back to me once.. no-one mentioned any names but I knew who it was .. I find that disturbing.. that's why I'm wary. Some Asian friends I'd never tell anything* (I asked why) *because it would be all over the community. "*

A number of the women mentioned a fear of 'gossip' and were very careful about whom they confided in. In a number of cases confiding was abandoned for fear of 'gossip'. The importance of trust is underlined in the cases reported above. In my opinion this is not unique to those South Asian women involved in this study. My own personal experience of growing up in a working class area of Edinburgh as a Catholic of Irish descent, where many individual, family and friends' activities centred around the Catholic church (be it the Women's Guild in the case of my mother, or my own involvement in the church social club and the ritual of mass every

Sunday morning) meant that if so desired, knowledge of other families' affairs was not difficult to acquire. For many this had two consequences: first, a desire to know 'the gossip' and secondly a strong desire to keep any difficulty or controversy in one's family very quiet. Thus, trust may be especially important for individuals from minority communities.

Understanding

An example of the importance of this phenomenon operated with **gm6nd** who could confide in her husband on 'most things', but not on her difficult upbringing and how it impinged on her present life, in terms of both her own personal life and the upbringing of her daughters. She felt her husband '*did not understand what happened*' to her and how this affected her own personal feelings at times and her strong views on her daughters' upbringing. She had tried but had 'given up'. Again where the severe event is involved, confiding on the issue was not possible, thus exacerbating its effect.

Ready Access

I would argue that merely identifying someone in whom a person can confide is, in and of itself, not sufficient to act as the buffer that confiding relationships are thought to represent to severe events or major difficulties, but that the frequency of contact with confidants is equally important. In the case of a number of women in the depressed category, confidants were indeed available but not on a regular basis. Seven out of 23 women named individuals they could confide in but the strength of this relationship was adversely affected by the fact that such confidants were not available on a regular basis, which weakened the confiding ties. The question of access to confidants is, therefore, very important and one could speculate that as a consequence of marriage patterns and internal migration, as the majority of marriages are arranged outwith the bride's home town, this can result in many women moving to another part of the country and losing regular contact with their own family who can contain their main or sole confidants. South Asian women, more than white indigenous women, can thus potentially face the prospect of losing regular contact with their main confidants.

Gender and Confiding In South Asian Women

Whilst acknowledging that confiding relationships could be developed with a close friend, sister or mother, Weiss (1969) was of the opinion that marriage or dating was the bed-rock of confiding relations, whilst at the same time noting that a sexual relationship was not a necessary precondition for a confiding relationship, a view shared by Brown and Harris (1978). In this study a significant number of women with strong confiding relationships named persons outwith marriage or dating relationships: sisters, close female friends or mothers, or female in-laws. Additionally, a significant number of women with moderate or weak confiding relations named other females, sisters, close female friends, as their confidants. This suggests that Brown and Harris' view that strong confiding relationships have, to a significant extent, their foundation in married or dating relationships is not wholly applicable to South Asian women interviewed in this study.

This conclusion derives from the finding that the strongest confiding relationships, in both depressed and non-depressed groups, were with sister/s and close female friends (and to a lesser extent mothers) whom the women were able to see frequently. In the case of moderate and weak categories: once again, sisters and close friends and (to a lesser extent mothers) were mentioned as confidants.

In the depressed group, those who had weak confiding relationships named nine females as confidants (six named sisters, one sister-in-law, one close female friend, one mother) but had major access problems which made regular confiding impossible. In relation to the non-depressed group, 18 women in strong confiding relationships named females as close confidants. Seven named their husbands as close and regular confidants, these seven also had two other females they could confide in, these being a sister and close female friend. Three women named their sisters as well as husbands; two women named husbands and close female friend. One named husband only. Three women named close female friends as sole regular confidants, whilst two women named close friends. Of the women in the non-depressed category with moderate confiding relationships, five named female-only confidants, three

sisters, one close friend, one female cousin. This suggests that, in contrast to Brown and Harris' findings, more South Asian than white indigenous women named same-sex confidants when it came to confiding relationships.

Given the nature of confiding relationships in South Asian women in my study, it would be useful at this juncture to record the points of Ahmed (1981), Shaw (1988) and Cochrane and Stopes-Roe (1990) with respect to confiding relationships. Ahmed (1981) notes that in many Asian communities, though not in all, husbands and wives continue to seek emotional support not so much from each other, especially in the early years of marriage, but from members of the broader kinship system: i.e. from their own parents, brothers and sisters. Shaw (1988) states that in contrast to the ideals of the western system, marriage in the Pakistani community is not regarded as, or expected to be, a person's primary emotional investment. And, like Ahmed, Shaw notes that often an individual's ties with parents, brothers and sisters are more important. Following their analysis of confidant support in South Asian families in the West Midlands, Cochrane and Stopes-Roe (1990) noted that whilst 42 named their partners, young South Asians "*tended to remain primarily dependent on their families of origin for support* " (1990:81).

Conclusion

The findings reported above highlight the importance of the immediate family, and in particular sisters, in providing frequent confiding support among South Asian women. We also see the negative effect that being separated geographically has in weakening confiding relationships. Where a lack of understanding on the part of a confidant emerges, this also serves to weaken the confiding bond. Also important was the role of close female friends in proving strong confiding relations.

We also see how inter-family dispute weakens confiding relationships. This demonstrates that the presence of family members can not be seen automatically as a form of support. The fact that families were a source of distress and served to weaken confiding relations in a number of

cases in this study indicates that those who chose family members (sisters in the main) as a source of confiding support is by no means universal. It is reasonable to assert, therefore, that for many second-generation South Asian women, the family of origin, particularly in the form of a sister, often provides the main basis for a confiding relationship. However, we should also note that the family can also be a source of stress and can have a negative impact on confiding relationships. What emerges is not a fixed picture, rather one that depends on individual family dynamics.

The question of trust is clearly evident in this study. The fear of 'gossip' prevented a number of women from confiding openly about personal concerns as they had no person they could fully trust. One could speculate that factors pertinent to the South Asian community come into effect here. In a South Asian context it has been reported that self-centredness can be associated with negative social and cultural values (Rack, 1982). In Eastern cultures more importance tends to be placed on relationships with others, unlike in a Western setting where the emphasis tends to be on the individual nature of the person. In the same vein, Webb-Johnson (1991) notes that in the South Asian community a person's needs and motives are based on relationships, primarily with family and community. Distresses are viewed as disorders of family relationships. As noted in a previous chapter, there is a clear distinction between South Asian male and female roles. Lack of satisfaction with these roles, challenging them or complaining about them could upset family relations. This may prevent some women talking about relationship problems or family problems as anything that disrupts *izzat* (male and family honour) or*biradari* (wider family network) is strongly discouraged. Beliappa (1991) notes that only 18% of those experiencing mental distress were prepared to talk about their problems and recorded that certain problems, such as marital conflicts, were not discussed within the family network. According to Krause (1989) this is why some GPs, who make an initial diagnosis of depression in South Asian woman, report a denial on their part followed by a breakdown in communication.

We see from the women interviewed in this study that a degree of isolation from confidants is implicated in their depressive illness. This finding matches those of Currer (1983) and Fenton and Sadiq (1991). Currer makes reference to the fact that lack of support women might have expected at home was implicated in women suffering depression, whilst Fenton and Sadiq found that one of the chief exacerbating and vulnerability factors in their study of depressed South Asian women was social isolation, including the absence of anyone to talk to on intimate terms. Beliappa (1991) also noted that those who were willing to talk about their concerns were less vulnerable to mental distress such as depression.

In this study, with cases of strong confiding relations, frequent access to at least one confidant served to buffer the stresses associated with depression. Moderate confiding relations were also beneficial. Where confiding relations were weak and very weak, the severe events (provoking agents) or major difficulties encountered by the women were not buffered and led to the development of depressive illness. It is important to note the points relating to differences that exist between South Asian women, notably the nature of their confiding relations, and those found in Brown and Harris' studies involving white indigenous women. In pointing out these differences I believe the basic model of Brown and Harris on the importance of confiding relations in buffering severe events (provoking agents) or major difficulties and in reducing the risk of depression was also found in this study and therefore applicable cross-culturally to involve women of South Asian origin.

Overall Summary Conclusions

Mental Illness in Britain's South Asian Community

As Chapter 1 demonstrated, there is evidence of a substantial range of mental illnesses among Britain's South Asian community. Significantly, many disorders such as bulimia and anorexia nervosa have been found in young South Asian women, disorders previously believed to be present only in western populations. Those studies identifying eating disorders, and those that have acknowledged an increasing rate of attempted suicide in young South Asian women, have, in addition to other factors, cited pressures on young South Asian women from a number of sources that have resulted in conflicts where gender has been a key factor. Young South Asian women have higher rates of 'parasuicide' and growing rates of eating disorders. Consequently, the idea that Britain's second generation South Asian women are immune from the social pressures that induce mental ill-health in their white counterparts is false. There are of course cultural and social factors that have to be recognised in the social impact of mental illness, and this is the case with white indigenous women also. However, it is my contention that a separate view which places the emphasis on culture and culture conflict as the key component in depression and mental health generally among second generation South Asian women in Scotland, fails to appreciate the social factors that lead to depression among such women.

Whilst the concept of self-esteem is, as Chapter 1 indicates, important in understanding why some South Asian women become depressed, the notion that these and other ethnic minority women become depressed soley as a consequence of the the fact that we live in a society where ethnic and religious minorities regularily experience racial and religious discrimination, seems overly simplistic. Such a standpoint fails to take into account the ability of ethnic and religious minority people's capacity to successfully fight against such discrimination and also, as I have tried to demonstrate in this thesis, fails to address other stressful life experiences which can increase the risk of depression in second-generation South Asian women in Scotland. The importance of self-esteem, however, is apparent when we look at how failure to achieve one's personal aspirations with respect to valued goals and aspirations is a significant in the onset of depression in second-generation South Asian women, particularly in the absence of strong confiding relations.

Identity: Maintanence and Change in South Asian Women

A clear majority of the women interviewed in my study, whilst they viewed their outlook and values as different to those of their parents, nevertheless remained significantly anchored to their Muslim, Sikh, Hindu or (in their words) Asian identity, although the strength of these attachments varied. It was significant that a clear majority of the interviewees chose to describe themselves as part Scottish. Although many expressed pride in their Scottishness, again a clear majority of interviewees rejected the notion that, from their own stand-point but not necessarily from the stand-point of some of their parents and/or own community, their Scottishness was not at odds with their Muslim, Hindu, Sikh, or Asian identity. Such views indicated, for a majority at least, that to integrate did not mean the abandonment of one's cultural heritage: rather, the redevelopment of this to live in a different, more modern, context. There were, however, a minority of interviewees who viewed change in a negative light and believed there were no benefits to be accrued from altering the cultural traditions as practised by their parents. This is not surprising. It demonstrates a diversity of attitude to such matters in the South Asian community that also applies, albeit with differences, in indigenous white communities.

The heterogeneous nature of the South Asian community is clear but so too is the heterogeneous nature within the individual religious groupings as demonstrated by the comments from Muslim women. Again, this is to be expected. Particular identities are not stable, despite common religious, traditional and cultural values: instead they change according to different forces operating on them. The experience of migration is undeniably a dual process, one of growth in a new direction where the group's own cultural traditions are modified to take account of their new environment, of expanding beyond the boundaries whilst simultaneously re-drawing boundaries. It is also a process of consolidation of that group's cultural and religious traditions as discussed in chapter 2. This process appears to be affected by the generational component. Many first-generation migrants were willing to go only so far in adapting whilst their children, in a majority of cases, felt the need to go further, to be more prepared to adapt, but not at the cost of abandoning certain cultural traditions. Following the

recent street violence in Bradford between sections of Pakistani youth and the police, many South Asian commentators spoke of inter-generational differences between the youth and older sections of that community. I believe that this and other studies suggest that the inter-generational component is an important factor in understanding the dynamics present in the South Asian community. Underlying this, however, is the gender issue and the determination of many second-generation South Asian women to adapt their own roles to suit their own values and aspirations. Where this desire is blocked conflicts can arise.

The significance of gender as an issue in modern contemporary society applies to all sections of society, not least the South Asian community in Britain. The idea that South Asian women are immune from the type of influences that their white counterparts in Britain or more specifically, in this study, Scotland face is obviously a false one. And, as with white women, some of these influences can result in a clash of values and aspirations when confronted with opposing values. In redefining their cultural identity, many second generation South Asian women do so differently from their parents and stress western values such as the equality of the sexes, greater freedom of choice in matters relating to marriage and occupation, and freedom to express dissent. In many instances, where clashes take place, these are successfully resolved by negotiation and discussion. However, in a number of instances such clashes can and do result in conflicts for some South Asian women. As this study indicated, some women in this position are now finding that roles assigned solely on the basis of gender can be restricting, which can result in traditional gender based roles being challenged and new roles that better suit the individual's own values and outlook being sought. This process does not automatically result in a depressive illness, as social supports can buffer such stressful events. Nevertheless, the stresses of the acculturation process for second-generation South Asian women are an important variable when considering aetiological factors implicated in the onset of depressive illness in this group.

Methodology

After considering the methodological and practical issues arising from this study, a few concluding comments would be useful. Ethnographic research of this nature can be problematic and/or flawed unless the researcher/s involved in the study are aware of and understand 'race' and gender issues both in society generally, in the South Asian community in particular, and in the interview process itself. In this thesis I contend that imperfections in data gathering, particularly in relation to the interviewer's part in the process, must be discussed. However, in the interpretation of research findings, researchers must be more prepared to recognise their complexity and avoid the dangers of reductionism that can arise out of looking at a single factor and suggesting that this factor alone explains everything.

Social Roles, Life Events and Depression

This study has attempted to show that Brown and Harris's and Brown's insistence on taking into account the social and cultural context, in addition to a person's biographical account of their circumstances, is applicable when attempting to understand why second-generation South Asian women develop depression: in particular, that loss and disappointment were the central features of most severe life events in second-generation South Asian women interviewed in this study. As Brown and Harris and Pearlin argue, recognising the importance of social roles helps us to understand the nature and impact of life events on second generation South Asian women. From this study it appears that social roles are implicated in life events among second-generation South Asian women, in particular the loss of a valued goal or aspiration relating to a particular role, as well as dissatisfaction with their present role in life.

Roles can be seen as patterns of behaviour and attitudes which serve as the basis for how persons see themselves and how they perceive how other people see them. The development of a social role is a complex process involving both the absorption of a range of social norms and obligations in that person's immediate environment, but over time is also the product of mixing with different groups of people whose views, outlook and behaviour can be different from those that prevail in that person's immediate environment. Flowing fromthis, I would argue that a person's social role is developed in part on the basis of personal experience, a

person's views and cultural values, and in part in accordance with guidelines shared by members of the society, sub-society, groups and sub-groups that person comes into contact with. This relationship can occur in a dialectical form with one side feeding off the other and vice-versa. There exist a number of possible outcomes from such encounters - role conformity, role change and role conflict.

On the basis of the data analysis in chapter 4 of this thesis I would argue that experiencing the loss of a valued ideal or goal, particularly relating to a social role, as well as strain over a social role was an important factor in the onset of depression in second generation South Asian women. When people experience problems with a role they are unhappy with, or have problems in achieving their ideal role, they are likely to react with concern as such difficulties experienced in such important areas of life are not easily treated with indifference. Roles are therefore clearly important when considering life events and depression. On the basis of what was said by those women who developed depression it appears that the social pressures they faced in undertaking a particular role, most commonly reported as that of a wife and mother, were in fact highly related to stressful experiences.

The findings suggest that a person's values, goals and aspirations, and how these manifest themselves in a person seeking a desired social role, are a key element in understanding the social origins of depression among those women interviewed in this study. This approach helps us to understand how and why social roles can, under certain circumstances, become associated with stressful events. Such a scenario can develop where a role is unwanted, where a person is bound in one role while wishing to play another, and where a person is unable to engage in role change as a result of various social pressures.Comments made by the depressed women in my study indicated quite strongly that loss and disappointment were critical factors in their depression. The notion of loss does include loss of a person and material/financial loss; but, critically, loss of a cherished idea, loss of aspiration concerning cherished ideals and values, and loss of a valued goal emerged as the most critical factors in the aetiology of depression. This is so because social roles play a critical part in the life

event process, in that loss of a valued idea, goal or aspiration relating to a social role can lead to role strain/conflict which can, in the absence of a confiding relationship, increase the risk of depression in women.

Evidence from the work of Brown and Harris (1978;1986) and Pearlin (1983;1989) indicates that events become stressful by impacting on social roles. As was shown in Chapter 1, research findings on role conflict and their association with stressful life events are not confined to white indigenous women. For the purposes of this thesis such findings take on a special significance when one looks at relatively recent research findings addressed in chapter 1 which have highlighted mental distress (notably depression) among second generation South Asian women in Britain and have shown a link between depression, stressful life events relating to conflict, and strain over social roles.

Acculturation and Depression

The significance of gender as an issue in contemporary social life applies to all sections of society, not least the South Asian community in Britain. The idea that South Asian women are immune from the type of influences that their white counterparts in Britain and, in this study, Scotland face is obviously false . And, as with white women, some of these influences can result in a clash of values and aspirations when confronted with opposing values. In redefining their cultural identity, many second generation South Asian women do so differently from their parents and stress values such as the equality of the sexes, greater freedom of choice in matters relating to marriage and occupation, and freedom to express dissent. In many instances, where clashes take place, these are resolved by discussion. However, in a number of instances such clashes can and do result in conflicts for some South Asian women. As this study indicated, some women in this position are now finding that roles assigned solely on the basis of gender can be restricting, which can result in traditional gender based roles being challenged and new roles that better suit the individual's own values and outlook being sought. This process does not automatically result in a depressive illness, as social supports can buffer such stressful events. Nevertheless, the stresses of the acculturation process for second-generation South Asian women are an important variable when considering aetiological factors implicated in the onset of depressive illness in this group.

In chapter 5, we see that loss through role conflict was a factor in the onset of depression in 13 women. Typical of the experiences found in this group were gm5d, gm7d, and es1d where the women experienced conflicts with parents and/or husbands. Experiencing role conflict constituted a stressful life event. However, chapter 2 showed 19 of the 46 women interviewed were 'pro-change' with respect to their role as women and their children's upbringing. This tells us that not every woman who was 'pro-change' experienced strong role conflict and not every 'pro-change' woman became depressed. The strength of the conflict and the ability to resolve the conflict were important but so too were the availability of a strong confiding relationship which acted as a buffer to the consequences of role conflict. Those women who experienced discord with their present and perceived future role in life and/or who saw no

possibility of their aspirations relating to their ideal social role coming to fruition, constituted a large section of the depressed sample. This could lead one to contend that under such circumstances, and in the absence of a strong confiding relationship, the possibility of developing depression increased.

If so, one could reasonably argue that the following situations centring on social roles could be described as representing aetiological factors in the onset of depression in second-generation South Asian women in Scotland. It could be argued that the processes and developments described in (i) to (v) below, are one consequence of the stresses associated with acculturation that are discussed in chapter 2:

(i) where a person is dissatisfied and in conflict with spouse and family over the behaviour and attitudes that flow from a role she is expected to perform and does perform (e.g. gm5d)

(ii) where a person who believes that the aspirations encapsulated in the fulfilment of their ideal role/s were not possible because such ideals conflicted with the strongly held beliefs of their immediate family and community (e.g. es2d)

(iii) where a person has tried and failed to fulfil an ideal role because such ideals conflict with the strongly held beliefs of their immediate family and community (e.g. em2d)

(iv) the realisation that one could only achieve such aspirations as a result of major upheaval and conflict which that person may be unwilling or feels incapable of going through successfully

(v) where a person is in continual conflict with family and/or community over her own desired actions and what other people expect of her.

(vi) where a person whose aspirations and hopes encapsulated in a particular role

(e.g. the woman who aspired to be the mother to a number of children) but had such aspirations blocked because of a miscarriage which meant she was unable to have children in the future.

Not all the women who experienced depression were 'pro-change' however . There were women in the 'flexible' and 'no-change' groups who also experienced depression. In contrast to the 'pro-change' group, women in the 'no-change' category held the view that change would weaken their identity and, in contrast to the 'pro-changers', believed strongly in maintaining, without change, cultural and religious traditions both in relation to themselves and their children. This did not however mean that such a stance would necessarily protect the woman from becoming depressed. In fact three women, gm9d, gm10d and gh3d, all in the 'no-change' category became depressed after experiencing stressful life events. In all three cases this was after experiencing loss but through specific events linked to their role as wife and mother. Gm10d believed strongly that no changes should take place in what she called *'the normal role of women'*. Her belief in the family as the fulcrum of everyday life was shattered following news of her father's infidelity and the subsequent break up of her own immediate family into two factions; those backing her mother and those backing her father. The woman felt a deep loss which was a key factor in her becoming depressed. In the case of gm9d, who believed that a woman's main role was as a wife and mother, her ability to fulfil such a role was dealt a severe blow after her husband left her. In the case of gh3d, whose stated role in life was to be that of a good mother to a large family , such a role was impossible following a miscarriage and the news that she was unable to have any more children. Role conflict, therefore, was also a factor in the onset of depression in the'no-change' group, albeit much less frequent than in the 'pro-change' group.

In the small sample interviewed in this study it emerged that loss through role conflict was a significant factor in the onset of depression in second generation South Asian women. This suggests that women who want more in life than the traditional role of wife and mother can experience conflict and when such conflict is unresolved, when their attempts to change

encounter resistance, this can increase the risk of becoming depressed. At the same time there are women who believe that the traditional norms and assumptions relating to wife, mother, and family should remain unchanged. Where this is disrupted, it can become a stressful life event which, where a confiding relationship is weak or absent, can lead to depression.

In the present study 'pro-changers' were found to constitute the largest group in the sample, suggesting that the process of arguing for change, and possible ensuing conflicts over women's roles, is becoming more widespread in second-generation South Asian women. As was the case in my study, this can be a factor in the onset of depression where the aspiration for change in relation to the woman's desired social goal is blocked, the resulting conflict is unresolved and the woman has no one to confide in. Not all the 'pro-change' women were however in the depressed category. In this study there were 'pro-change' women who experienced no conflict and achieved their goals. There were 'pro-change' women who experienced conflict and the conflict remained resolved. There were also 'pro-change' women for whom the conflict was unresolved but for whom the presence of a strong confiding relationship also buffered the effects of such conflict. In this study the expressed desire for a change in social roles was a prominent factor in the views of second-generation South Asian women in Scotland. Although prominent, it was not the only outlook.

At the same time the study identified women who believed very strongly in holding on to those traditional values related to being a wife and mother. The 'no-changers' were the smallest of the three categories but nonetheless significant. When the 'no-change' women experienced role conflict, where their aspirations of being a wife and mother in the traditional vein could not be met, and there was no or weak confiding, this proved to be a key factor in the onset of depression. While this was by far the biggest section in the role conflict category, role conflicts did not result only from a desire to change traditional roles for women. The removal of opportunities to engage in the more traditional role of wife and mother was also a key factor in the onset of depression among some of the women in this study.

It should however be noted that the nature of the loss was not uniform. Although a distinct category involved loss through role conflict involving loss of a cherished idea, loss of an aspiration concerning a cherished idea, reconfirmation of loss of a cherished idea and loss of a person and a cherished idea all emerged as distinct and significant categories. This is not to state that all the depressed women in this study experienced role conflicts; rather that because of factors already explained, loss was a significant aetiological factor.

Whilst the concept of loss is of critical importance, there are a number of situations where a severe event not involving loss is a factor in the onset of depression. These tend to be acute, unexpected events such the sexual harassment experienced by gm8d. There is also a restricted class of difficulties called major difficulties, which have to have lasted for at least two years, which also appear to be involved in the onset of depression in some of the women. As with loss, such events do not automatically lead to depression, the availability of a strong confiding relationship being a key determining factor. In this study, chronic difficulties leading to depression were present in 5 cases. These difficulties mainly related to family disputes. Although not fundamentally dissimilar to chronic difficulties like those found in Brown and Harris's studies, there are a couple of factors particularly pertinent to South Asian families. One factor is the pooling together of resources in business, house ownership/occupation, and child care that existed in a number of families. Although not as common as in the past this pooling together of resources did lead to chronic difficulties in the case of eh1d, gh2d, and gs1d. This was evident in the example of gs1d where two families living in the same house constantly argued over the running of the house and their small business. In the case of gm1d, the chronic problem related to persistent financial worries and racist abuse from neighbours.

Confiding

As regards the significance of regularly accessible confiding relationships, this is as important a factor in offsetting depression in South Asian women as has been found in the studies by Brown and Harris and those adopting a similar approach. This finding indicates that whilst family members, especially sisters, can be and are a source of support for second- generation South

Asian women, family members can also serve as a stressor adversely affecting the women's situation. Whilst for many of the women interviewed in this study confidants were of the same sex, unlike what was found in the Brown and Harris studies, regular availability was often a problem because of sisters moving to different parts of the country following marriage. An additional feature here, given the tight-knit nature of many of the communities the women lived in, was a reluctance to divulge personal problems except to very close people, for fear that this would be openly discussed in the wider community.

Conclusion

In conclusion, this study indicated that the process of acculturation in second-generation South Asian women resulted in a majority of women wishing to re-develop their cultural traditions in the new context in which they found themselves. Important in this was the issue of gender and a feeling that expectations surrounding the traditional roles of women in the South Asian community were inappropriate for a majority of second-generation females. Where women clashed over this factor, this emerged as a severe life event, although not all the women experiencing such conflict became depressed. The presence of a strong confiding relationship, and the ability to resolve the conflict satisfactorily in the woman's favour buffered these life events. The study also lends support to the notion that loss associated with personal aspirations and goals can, in the absence of a strong confiding relationship, increase the risk of depression for South Asian women. To a lesser extent, on-going major difficulties, in the absence of a strong confiding relationship, increases the risk of depression in the same group of women. Lastly, there exists a much smaller category, severe event without loss, which, in the absence of strong confiding relationships, increases the risk of depression. A significant difference in relation to Brown and Harris's model was that confiding in the South Asian women was with someone of the same sex, usually a sister or friend, unlike in Brown and Harris's studies where it was usually a husband or boyfriend.

Whilst saying this, one has to re-iterate a key point in the Brown and Harris approach. That is the importance of understanding life events and their role in the onset of depression, from

the person's own personal situation, their experiences, hopes and aspirations and values and goals in life. This is particularly important for South Asian women born in Scotland to parents who migrated to Scotland in the 1950's and 1960's, whose values and outlook were shaped in their countries of origin. Many families will successfully adapt their lifestyle to incorporate some cultural traditions present in Scotland. Some will find the transition more difficult, while some will not want to adapt at all. Their children however, have different experiences. Although brought up surrounded by the traditional values of their parents, their educational and social experiences introduce alternative and sometimes different values and traditions. This study suggests that this second-generation will want to maintain these cultural traditions but re-shape and modify them. Chapter 2 shows a number of different outcomes. One outcome is the development of a conflict over the role of young women. This may be resolved successfully. However, another possible outcome is unresolved and/or continual conflict over a woman's role. Such a development can lead to depression in the absence of a strong confiding relationship. This is not to say that the experiences of second-generation South Asians are the same as those of indigenous white women. The detail can be and is different. And it is this detail that one must first comprehend before commenting on life events and their part in depression among second-generation South Asian women in Scotland. Although agreeing that one must recognise the differences that can exist among first-generation South Asians and their attitudes to and presentation of mental illness, on the basis of this study the processes and developments leading to depression in second-generation South Asian women in Scotland are fundamentally similar to those outlined by Brown and Harris in their social origins of depression model.

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Appendix 1

Summary Details of Each Interviewee Including:

Demographic Details

HAD Scores

Life Event Experiences

Strength of Confiding Social Support

Table 1(Depressed Interviewees)

Table 2 (Non-depressed Interviewees)

Interviewee	Role Conflict	Inter-family Dispute	Stresses	Confiding	Social Network
gm4d Social Class 3N Age 25 No. Children 2 HAD Score(15)	**with parents over upbringing, staying on at school, boyfriends, marriage, then *with husband over career and **over role as mother and housewife, also * argument with sister over her lack of satisfaction with home and family life.		*financial difficulties	weak, not in husband and no longer with sister following argument	weak
gm5d Social Class 3N Age 28 No. Children 2 HAD Score (15)	**with parents over upbringing, staying on at school.	-	*death of mother one year ago.	weak, not in husband. With sister but access problems	weak
gm6d Social Class 3M Age 29 No. Children 2. HAD Score (13)	**with parents over upbringing, staying on at school, and career.	-	*death of mother one year ago.	weak- feels husband doesn't understand what she went through. Yes in sister but access problems as she also suffers depression.	weak

Table 1 Depressed Interviewees

gm7d Social Class 4 Age 29 No. Children 2 HAD Score (15)	**with parents over upbringing, staying on at school , and* over marriage, then * with husband over career also *argument with in-laws over children's upbringing.		-	weak, not in husband, no other available confidants.	weak
em1d Social Class 3N Age 34 No. Children 3 HAD Score (14)	**with parents over upbringing and marriage and * over boyfriends, then ** with husband over career, also *argued with mother-in-law over career.		-	weak, not in husband, yes in sister but she lives in England.	weak
em2d Social Class 4 Age 28 No. Children 1 HAD Score (14)	**with parents over marriage and * over upbringing and staying on at school, then ** with husband over career and her not wanting to live and work in a village in Pakistan		*doesn't want to go back to husband's village in Pakistan.	weak, not in husband, yes in sister and mother but they live in England.	moderate-recently involved in Asian women's support group.

gh1d Social Class 3N Age 30 No. Children 2 HAD Score (15)	** with husband and mother-in-law over her behaviour and outlook and* over career.		** domestic violence and *over financial pressures	weak, not in husband, yes in sister but she lives in Dundee	weak
gh4d Social Class 3N Age 31 No. Children 3 HAD Score (15)	**with parents over boyfriends and marriage. Parents refused to sanction marriage with white Scottish man.	-	*finds job in unemployment benefit office difficult at times because of abuse.	weak, not in husband yes in sister but she lives in England.	moderate, goes to temple weekly.
eh2d Social Class 3N Age 24 No. Children 2 HAD Score (13)	**with husband over his expectations of her role in marriage, bored and unsatisfied with mother and housewife, also ** with husband over career.	-	-	moderate, can confide in sister when sees her at fortnightly family gathering but difficult getting privacy to confide	moderate, family get together but can find this event stressful

es1d Social Class 4 Age 26 No. Children 2 HAD Score (15)	** with parents over upbringing and being taken out of school, then ** with husband over her demands of housewife and mother which she found unsatisfying.	-	*literacy problems	weak, not in husband yes in sisters but they live in Glasgow.	weak
es2d Social Class 3M Age 29 No. Children 2 HAD Score (14)	*with parents over upbringing, staying on at school, then ** with husband over her desire to go to college.	-	-	weak, not in husband, sister lives in England	weak
gs1d Social Class 3N Age 28 No. Children 2 HAD Score (13)	-	**with in-laws over house and family business	*financial worries over selling of house and buying over brother in-law's share of business	weak, not in husband, and no longer in sister-in-law following family dispute	weak

gm3d Social Class 5 Age 31 No. Children 3 HAD Score (13)	*with parents over staying on at school and over career		*financial worries, husband out of work ** fighting with cousins over her children, developed into long-term verbal and sometimes physical dispute	weak, not in husband, access problems as sister lives in Edinburgh.	weak
gm8d Social Class 3M Age 28 No. Children 1 HAD Score (15)	-		** experienced sexual harassment.	strong, yes in husband and sister but feels cannot discuss sexual harassment with sister and feels awkward discussing his brother it with husband as upsets him	moderate
gm10d Social Class 3N Age 34 No. Children 3 HAD Score (15)	-	**father's infidelity led to family argument and break up of close family bond with women excluded by members of her family.	*feels unable to go out and mix socially due to family situation, isolated in home	Moderate, yes in husband, but feels awkward doing so as the problem is with her own family, not his. No longer with sister following family break up	weak

gh2d Social Class 3N Age 29 No. Children 2 HAD Score (15)	*with parents over staying on at school and career	**with in-laws sharing same house, leads to arguments with husband. Feels privacy being invaded.	* overcrowded house.	moderate, yes in sister but only by letter, She feels she has to hold back in case they are found with something sensitive in them	moderate
eh1d Social Class 3N Age 26 No. Children 2 HAD Score (14)	*with husband over career	**with in-laws over how she raises her children and runs her home. She also believes in-laws interfere in her relationship with her husband (this is not over her role but on organisational matters e.g. budget, shopping).	*finds bringing up children on own a strain as husband works away from home.	weak	weak
gm1d Social Class 4 Age 32 No. Children 1 HAD Score (13)	-		** severe financial problems, overcrowded house, racially abusive neighbours.	weak, not in husband,access problems with only confidant who is ill	weak

gm2d Social Class 4 Age 30 No. Children 3 HAD Score (13)	-	*occasional arguments with in-laws over family shop	**financial problems and recent death of close relative who was woman's close confidant.	weak, not in husband. Close confidant recently died	weak
gs2d Social Class 3N Age 30 No. Children 3 HAD Score (15)	*with parents over staying on at school	-	**recently discovered that husband was having an affair, impending marriage break up, *financial worries once separated from husband.	moderate, can confide in sister but access is made difficult by presence of mother-in-law	weak
gm9d Social Class 4 Age 31 No. Children 3 HAD Score (14)	*with husband over career	-	**finds looking after children in house very stressful, has one child with illness, * financial worries	weak	weak
gh3d Social Class 3N Age 28 No. Children 1 HAD Score (13)	-	-	**recent miscarriage told by doctors unable to have more children	strong, can and does confide in husband	weak

Interviewee	Role Conflict	Family Conflict	Stresses	Confiding	Social Network
gh1nd Social Class 3M Age 27 No. Children 2 HAD Score (4)	*with husband over her role in marriage and career	-	-	Strong, partially in husband and fully in close friend and sister who she met with regularly.	Strong, part-time evening classes, keep fit classes. Regularly met friends
gm8nd Social Class 3N Age 28 No. Children 2 HAD Score (5)	**with some in-laws and sections of the community over her proposed career	* some in-laws disapproved over her career choice	-	strong, with husband, and sister	strong, active in local community based group.
gh4nd Social Class 3N Age 27 No. Children 2 HAD Score (4)	*occassionally with husband over career	-	-	Strong, yes in close friend	moderate, weekly attendee at education classes

Table 2 Non-depressed Interviewees

gm7nd Social Class 3M Age 25 No. Children 2 HAD Score (4)	* occasionally with husband over her career ambitions and role in house	-		Strong, with close friends and sister. Partially in husband	Strong, fortnightly get together with friends.
es1nd Social Class 3N Age 29 No. Children 3 HAD Score (3)	*with parents over staying on at school and *with some in-laws and sections of community over her job.	-	*occasional racial taunts at her children	Strong, in husband and two close friends	strong, active member of Sikh women's group.
em3nd Social Class 3N Age 26 No. Children 2 HAD Score (5)	*with parents over upbringing, then ** with parents over boyfriends and marriage.	-	*A racially abusive incident in recent past.	Strong, in sister and close friends.	Strong, member of Asian woman's group.
gm3nd Social Class 3N Age 26 No. Children 1 HAD Score (5)	-	occasional arguments with husband and in-laws over working in shop	*miscarriage 2 years ago sometimes troubling	Strong, in close friend and sister	Strong, family get together once per week, also member of keep fit group.

gm6nd Social Class 4 Age 27 No. Children 2 HAD Score (4)	-	occasional arguments with in-laws resulting from them telling her how to bring up children. Soon moving out of in-laws house into new dwelling so feels can put up with it.	*neighbours can be racially abusive to her children at times	moderate, yes in sister but has problem getting time as has 3 jobs and children to look after	Strong, in local community centre nursery.
gm1nd Social Class 4 Age 25 No. Children 2 HAD Score	-	occasional arguments with sister and sister-in-law over child care arrangements	*worries sometimes over finances but said always manages with bit to spare	*Strong, yes in husband and close friend	Strong, weekly get together of friends.
gm2nd Social Class 3N Age 28 No. Children 1 HAD Score (3)	-	-	*miscarriage two years ago sometimes troubling	Strong, with close friend and sister. Not in husband	In educational group meets weekly

es2nd Social Class 4 Age 25 No. Children 2 HAD Score (3)	-	-	* occasional problems with immigration authorities when relatives visit	strong, in sister .	Weekly get together of friends
gm4nd Social Class 3N Age 30 No. Children 2 HAD Score (4)	-	-	*Children occasionally get into trouble at school	Strong, in husband and close friend	weak
eh1nd Social Class 4 Age 24 No. Children 2 HAD Score (5)	-	-	*House too small, wants to move but can't find buyer for present dwelling	Partially in husband. Strong with 2 close friends.	Works part-time meets many friends through this work
em2nd Social Class 4 Age 28 No. Children 3 HAD Score (3)	-	-	Occasional racial taunts	Strong. In husband, sister and close friend	Member of women's group that meets weekly

gh3nd Social Class 3N Age 29 No. Children 3 HAD Score (4)	-	-	*husband works away, finds bringing up children on own a strain	Not in husband, Strong with cousin but sees irregularly	weak
gs2nd Social Class 3N Age 24 No. Children 1 HAD Score (4)	-	-	*noisy neighbours	Strong in close friend. Not in husband	weak
gh2nd Social Class 3N Age 31 No. Children 3 HAD Score (4)	-	-	*sometimes finds college work a strain	Strong in husband and friend	Many friends through college sees daily
gs1nd Social Class 3N Age 28 No. Children 3 HAD Score(5)	-	-	*sometimes worries that children will loose Sikh identity	Strong, in husband	Sees friend on regular basis. Meet in their own homes

em1nd Social Class 4 Age 31 No. Children 3 HAD Score (6)	-	-	*concerned over possible discrimination her children will face growing up here. Based on her own experience	Strong, in husband, two close friends	Goes to women's' group once a week
eh1nd Social Class 4 Age 27 No. Children 2 HAD Score (6)	-	-	*financial worries over husband's business	Strong, in sister and close friend	Sees friend once a week
gm9nd Social Class 4 Age 30 No. Children 3 HAD Score (4)	-	-	-	Strong, in two sisters and sister-in-law	In educational group meets once per week
gm10nd Social Class 3N Age 31 No. Children 2 HAD Score (3)	-	-	*concerned over mother who is ill	moderate, in sister who she sees every 2 months	Member of keep fit class, meets weekly

gm11nd Social Class 4 Age 27 No. Children 2 HAD Score (6)	-	-	*son is asthmatic, concerned about his overall health	Strong, in two close friends	weak

Appendix 1b

Demographic Characteristics of Scotland's South Asian Population

Scotland's South Asian Community : A Summary based on the 1991 Census

- The 1991 census showed Scotland's ethnic minority population to be 62, 634 or 1.3% of the total population.

- South Asian people are the largest ethnic minority grouping in Scotland with a population of 32, 376.

- Scotland's South Asian communities breaks down as follows:

Pakistani - 21, 192 (65.8% of Scotland's South Asian population)

Indian - 10, 050 (31% of Scotland's South Asian population)

Bangladeshi - 1, 134 (3.5% of Scotland's South Asian population)

- The Pakistani community is the largest ethnic minority grouping in Scotland, constituting one third of Scotland's ethnic minorities. Although large in Scottish terms, only 4.5% of British Pakistani population live in Scotland.

- Of the 32, 376 South Asians living in Scotland, just over 60% live in Scotland's 4 main cities. This urban concentration is dominated by Glasgow where approximately 1 in 3 of all ethnic minorities live and the Pakistani community is in the majority.

Scottish Cities	Number and % of South Asian pop. who are Indian	Number and % of South Asian pop. Pakistani	Number and % of South Asian pop. Bangladeshi
Glasgow	3, 374 (10.4%)	10, 945 (33.8%)	191 (0.6%)
Edinburgh	1, 171 (3.6%)	2, 625 (8.1%)	328 (1.0%)
Aberdeen	303 (0.9%)	154 (0.5%)	165 (0.5%)
Dundee	628 (1.9%)	1, 157 (3.6%)	119 (0.4%)

Social Class and Scotland's South Asian Community

Social Class	Indian	Pakistani	Bangladeshi
1	17.1%	4.7%	16.7%
2	38.6%	54.6%	6.7%
3n	20.6%	24.0%	30.0%
3m	9.7%	6.5%	23.3%
4	9.7%	7.1%	13.3%
5	1.3%	0.4%	6.7%

Taken from Dalton, M; Hampton, H. Scottish Ethnic Minority Research Unit. Fact Sheet 1. October 1994

APPENDIX 2
Interview Schedule

Semi-Structured Interview Schedule

Introductory Points

I spoke about myself, my background, and how I came to be doing this research.
I expressed my appreciation to the woman for the interview and giving up their time for the interview. I stated that everything that we spoke about was between ourselves and was completely confidential.

What we talked about (not necessarily in this order).

Age, religion, where born.

Educational experience: years in formal education. Educational experiences, likes and dislikes. Reasons for likes and dislikes. What were career intentions on leaving school, were intentions fulfilled. If yes, in what way and why. If not, in what way and why. Attitudes at the time. Current attitudes towards such feelings.

Further education and/or training. Working position past and present. If working, do you enjoy job. If worked in past did she enjoy job. Fulfilment in such jobs. Career intentions in these circumstances.

Present day career intentions; circumstances surrounding these intentions. Can they see such intentions being fulfilled. If yes, why. If no, why. Feelings about this.

Marriage. What age married. Background to marriage. Feelings about background to marriage. Husband's details past and present.

Children: number and age of children. Views on children's upbringing. Why such views are held. Contrast to her own experiences. Do they think this will be positive or negative given her own experience. Reasons behind such views.

General question in summary relating to current views relating to marriage, jobs, education in her own community in general. What opinions taken into account and why.

In the interviews the women would raise a number of issues and which I asked them to expand on.

Religion : importance of religion in their life- guiding principle/s, how much religion features in woman's life. Views on this. Is religion more or less important for her husband. What role would she like to see religion playing in her children's life.

Clothes- clothes worn. What is worn where and why. Preferences.

Living in Scotland. Where-else has the person lived, if any. Attitudes on this.

What are traditional values. What do you mean by culture, Asian and British. Are there differences. What are these. Opinions on this.

You feel different from British/Scottish people, why. You have more in common with British/Scottish people, why. Do you feel different from British people. Yes, why/no why. How you see yourself.

Attempt to contrast life before and after marriage. What differences since married. Attitudes to this. Views on child care and domestic duties and responsibilities.

Confiding

Questions on confiding are addressed in Chapter 3. However, a number of general points were also addressed in the interview relating to social contacts.

Practical Support

How much did person need/given in relation to practical support with tasks.

How much would they have liked more practical support.

Social Contacts

Contact with relatives. Contact with parents if alive, if not what age was woman when parent/s died. Contact with friends and acquaintances. Membership of clubs or organisations. Attendance at these organisations. Benefits of membership and attendance. Desire to join organisations. Does person mix with members of indigenous population. any friends from indigenous population.

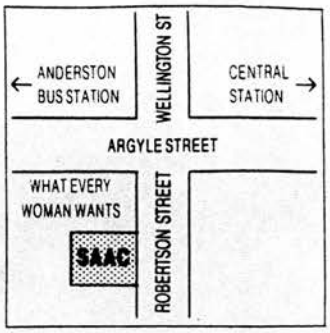
APPENDIX 3

Selection of Letters of Support

SCOTTISH ASIAN ACTION COMMITTEE

Suite 5, Second Floor
73 Robertson Street
Glasgow G2 8QD

Telephone: 041-248 5033
Fax: 041-226 5308



To Whom It May Concern

14th February 1992

Dear Sir/Madam,

The Scottish Asian Action Committee is an umbrella organisation representing a large number of Asian organisations in Scotland. We have a number of functions including the provision of an advice and information centre to help Asian people deal with any problems they may face; to assist the Asian communities to participate in local community life and to liaise with the Local Authority and other bodies; and to gather information relevant to Asian communities.

We have recently been contacted by Eddie Donaghy who is a post-graduate student at Edinburgh University researching the relationship between the Asian community in Scotland and the mental health services. We have discussed Mr Donaghy's research proposals with him at some length and we wish to declare our support for research of this nature. Research into mental health issues amongst the Asian community in this country is important and long overdue and we have no hesitation in expressing our support. Given the importance of this work, we hope that Mr Donaghy will receive the financial support neecessary to conduct his research programme.

Yours faithfully,

pp. A. Samad.

G S Soofi JP
Secretary

SHAKTI WOMEN'S AID

12 Picardy Place, Edinburgh EH1 3JT.

Tel: (031) 557 4010

TO WHOM IT MAY CONCERN

Shakti Women's Aid supports the study on Black People and Mental Health that Eddie Donaghy is embarking on. We understand that due to financial constraints he is concentrating on one specific minority ethnic group, the Asians, and it is our hope and belief that resources which are so desperately needed will be made available now and for future research to cover all Black groups within Scotland. Our great concern is that resources are made available only to cover studies done with minority ethnic groups that are large in numbers and this disadvantages the other groups which do not carry such a recognisable feature of great numbers.

Shakti Women's Aid is a black women's group set up five years ago to confront the issues of violence against black women. Shakti is the only women's group in Scotland providing service to women of all minority ethnic origins and sees violence as including all oppression experienced by black women for example, personal racism, racism and discrimination in employment, health, housing, education, immigration, choice of religion, as well as physical, sexual and emotional abuse.

The area of mental health is one which causes our project great pain because we feel we lack statutory support thereon. The difficulty we face in trying to refer women who use our service to appropriate agencies frustrates an element conducive of recovery within these women's lives. We are weary of referring Black women to agencies which do not show or share cultural sensitivity in their service provision.

We hope support for Eddie's study will reveal the need for the appropriation of mental health services in order that they positively benefit the whole population of Scotland.

Yours sincerely

Jackie Lamola
on behalf of Shakti collective

The Asian Family Counselling Service

74 The Avenue · Ealing · London W13 8LB
Telephone · 081 · 997 · 5749

Mr. Edward Donaghy,
Department of Social Policy and Social Work
The University of Edinburgh
Adam Ferguson Building,
George Square,
Edinburgh EH8 9LL

9th September, 1992

Dear Mr. Edward Donaghy,

Thank you for your letter of 20th August, 1992.

Your subject of research is very wide and there is very little written research on the factors that influence the onset of depression in Asian women.

I am in the process of writing a book on the subject of modern Asian marriages and depression and loneliness of women forms a chapter. Asian women are far more dependent on other women for emotional support than the indigenous British women. The Asian women's mental and physical happiness depends on whether this emotional support is available to them. When the extended families lived together or close to each other, it was possible to get the support from each other, now the women live in nuclear families and they find themselves and their marriages under strain.

I have been carrying out a small research by way of holding seminars in different parts of the country with Asian professional women. I want to arrange such a seminar in either Glasgow or in Edinburgh, if I can find someone local who can contact the Asian women's groups. If the seminar does take place, I will contact you so that we could have a meeting and talk about your research at greater length. If you can suggest whether you can help in any way in organising the seminar, I would appreciate it. I don't have much contact with any organisations in Scotland and yet we can referrals for counselling from many parts of Scotland.

You might contact Lynfield Mount Hospital, Heights Lane, Bradford, which has a multi-cultural unit. Dr.Bavington is the head of the unit (although he is ill at the moment) but someone from his department could give you proper statistics about depression and Asian women. They have done a vast amount of research in the subject.

Yours sincerely,

Rani Atma

Rani Atma
Director

PATRON	LORD CHITNIS
REGD. CHARITY No.	517595
DIRECTOR	RANI ATMA

THE MENTAL HEALTH FOUNDATION SCOTLAND

24 George Square
Glasgow G2 1EG
Tel: 041-221 2092
Fax: 041-204 2606

LMS/ML

21st March 1994

Eddie Donaghy
Department of Social Policy and Social Work
The University of Edinburgh
Adam Ferguson Building
George Square
EDINBURGH
EH8 9LL

Dear Eddie,

Many thanks indeed for sending me the copies of your interim report. You have managed to put a great deal of information down very succinctly and I am delighted to see that things are progressing so well with your work.

I will ensure that our Scottish Executive Committee has the opportunity to read your paper prior to our next meeting as I have no doubt there will be some discussion on its content.

I will let you know if there is anything really controversial in what we say although I would not anticipate this.

Please get in touch anytime and I will look forward to hearing from you over the months to come.

Keep up the good work.

All the best.

Yours sincerely,

Lynda.

LYNDA M. SOMERVILLE R.G.N., S.C.M.
DIRECTOR

GREATER GLASGOW HEALTH BOARD

MENTAL HEALTH UNIT — EAST SECTOR

Our Ref: MH/DF

If phoning please ask for Dr Hand

10 February 1993

Mr Edward Donaghy
Department of Social Policy and Social Work
The University of Edinburgh
Adam Ferguson Building
George Square
EDINBURGH
EH8 9LL

Dear Mr Donaghy

Thank you for your letter. I would be happy to allow you access to any Asian patients under my care. However, at the moment, I have none. I will, however, keep your letter, and if any patients are admitted to hospital under my care who fulfil the criteria you have set out in your letter, I will get in touch and perhaps then we could discuss further details of your research.

Yours sincerely

Maggie Hand

MARGARET HAND
CONSULTANT PSYCHIATRIST

☐ ACORN DAY HOSPITAL
23 Acorn Street
Glasgow G40
041-556 4789

☐ SHETTLESTON DAY HOSPITAL
150 Wellshot Road
Glasgow G32
041-778 8381

☑ CARSWELL HOUSE
5 Oakley Terrace
Glasgow G31
041-554 6267

☐ CRAIL STREET CLINIC
155 Crail Street
Glasgow G31
041-554 1464

ANY CORRESPONDENCE SHOULD BE DIRECTED TO THE HOSPITAL INDICATED

MR. E. DONAGHY
DEPARTMENT *of* SOCIAL POLICY
and SOCIAL WORK

DR. C.L. ANAND MBBS (PB) MRCP Glas. & Edi

77 Dunard Street, Queens Cross
Maryhill Road, Glasgow G20
Telephone: 041-945 1718

10/12/92

Dear Mrs

You may remember that I spoke to you some time ago about a colleague of mine who is doing an investigation on the circumstances of Asian women who have the general and occasional feelings of being weak, tired and listless. You stated that you would be prepared to take part in an interview with the researcher, Mr. Edward Donaghy, if he contacted you. I understand that Mr. Donaghy is ready to begin his interviews in January and myself and Mr. Donaghy are writing to you to ask if it would be possible to arrange a date and time for the interview . The interviews can be organised whenever and wherever you want. We have enclosed a form for you to fill in telling us (1) if you are still prepared to take part, (2) the time and date you would like the interview to be organised and (3) where you would like the interview to take place.

We hope you will be prepared to take part in the study which will help us understand this area of concern and the best way of helping Asian women with such feelings.

We have enclosed a stamped addressed envelope for your reply and look forward to hearing from you.

Yours sincerely,

Dr C L Anand. Edward Donaghy.

Salford Health Authority

North Western
REGIONAL DRUG DEPENDENCE SERVICE

Prestwich Hospital, Bury New Road, Prestwich, Manchester M25 7BL
Tel: 061 773 9121 Fax: 061 773 8186

2.3.92

Dear Mr Danagy

In response to requests for information on Asian suicide I am sending out the contents of the lecture I gave to the Annual Meeting of the Royal College of Psychiatrists in July 1990. This represents what I consider to be the most up to date summary of my own research.

Appended is a list of references on the subject. The only references that add anything significant to the enclosed lecture notes are those by Shah and Raleigh et al.. Due to the substantial delay in having research published it is likely to be at least a year before most of the findings reported in the lecture appear in print.

Yours faithfully, Also included are my lecture notes + copies of overheads on the T.V.S.

John Merrill

Consultant Psychiatrist.

APPENDIX 4

Selection of Correspondence with South Asian Organisations

Darnley Street Family Centre
175 Darnley Street
Glasgow
G41 2SY
tel 041 424 3920

ਡਾਰਨਲੀ ਸਟਰੀਟ ਫੈਮਲੀ ਸੈਂਟਰ
175 ਡਾਰਨਲੀ ਸਟਰੀਟ
ਪੋਲਕਸ਼ੀਅਲਡ
ਗਲਾਸਗੋ G41 2SY
ਫੋਨ: 041-424 3920

ڈارنلے سٹریٹ فیملی سنٹر
175 ڈارنلے سٹریٹ
پولکشیلڈ
گلاسگو G41 2SY
ٹیلی فون نمبر 041 424 3920

19th January 1993

Eddie Donaghy
Department of Social Policy and Social Work
The University of Edinburgh
Adam Ferguson Building
George Square
Edinburgh
EH8 9LL

Dear Mr Donaghy

Thank you for your letter of 14th January 1993. I would be most interested in meeting with you to discuss your proposed research study.

I am sure my colleague Ms Pratima Pershad, Depute for Health & Community would be able to provide a valuable insight into this area of work.

Please contact me by telephone to arrange a suitable time to meet.

Yours sincerely

Diane M Swales

Diane M Swales
Project Co-ordinator

Aims and Objects of PDA
The PDA is a local multi-racial membership organisation which aims to promote racial harmony, and serve the community through the provision of a community hall, developmental programmes, and active participation in matters of local concern.

PDA

POLLOKSHIELDS DEVELOPMENT ASSOCIATION
110 McCULLOCH STREET,
GLASGOW, G41 1NX
Telephone: 041-429 4249

CFD/RI

22 January 1993

Eddie Donaghy
Department Of Social Policy
And Social Work
The University Of Edinburgh
Adam Ferguson Building
George Square
Edinburgh
EH8 9LL

Dear Eddie

Thank you for your letter of 14/1/93 and I apologise for taking so long to reply.

I would be more than happy to meet with you at a mutually convenient time, so please contact me at the above telephone number.

As a matter of interest, I am at present compling a report into Dementia among Ethnic Minorities and what we can hope to do to support and help suffers, their carer's and families.

I look forward to hearing from you soon.

Yours sincerely

Chris F Downey

Chris F Downey
DEVELOPMENT WORKER

APPENDIX 5

List of Groups met with and Contacted

INDIVIDUAL GROUPS MET WITH
Lothian Racial Equality Council
Strathclyde Community Relations Council
Roundabout International Centre (Community Centre used by a range of Ethnic Minority Groups)
Nari Kallyan Shangho (NKS; a South Asian Women's Group)
Leith Sikh Group (A Sikh Community Group)
Scottish Association Mental Health (SAMH)
Saheliya (Ethnic Minority Organisation providing Counselling Services for Women)
Wester Hailes Representative Council (Organisation providing a range of help for Ethnic Minorities)
Glasgow Association Mental Health (GAMH)
Pollockshields Development Association (Community Group providing a range of services for South Asians in Glasgow)
Darnley Street Family Centre (Community Group providing a range of services for South Asian Women in Glasgow)
Scottish Ethnic Minority Research Unit (SEMRU)
Shakti Women's Aid (Black Women's Group in Edinburgh)
Lothian Social Work (Mental Health Director)
Southern General Hospital Department Psychiatry
Strathclyde University; Medical Research Council (Sociology Unit)
Housing Equality Action Unit
Racial Equality Action Unit (Glasgow)
Pilrig Ethnic Minority Women's Group
Asian Family Counselling
Confederation of Indian Organisations
Scottish Asian Action Committee

INDIVIDUAL CONTACTS
Before commencing and throughout my research I wrote and/or spoke with a number of academic, health and social work professionals working with South Asians in Britain in addition to this I corresponded with a number of overseas academics in Australia, USA and Canada who had carried out work of a similar nature to my own.

I also attended ten conferences on Ethnic Minorities and Mental Health.

Towards the end of my research I was invited to give a number of presentations on my research and its preliminary findings to a number of mental health conferences, lectures (involving psychiatric staff and students) and seminars. At one of these events, a conference of 100 South Asian women in Edinburgh, I was asked and agreed to chair the conference proceedings.